General Chiropractic Council
Meeting Agenda

5 December 2024 at 9:30 (Virtual)

	Item	Action	Presenter	Time
1.	**Welcome, Apologies and Declarations of Interest**		Chair	9.30
2.	**A. Council Minutes of 25 September 2024** **B. Matters Arising**	To approve	Chair	9.35
3.	**Chair's Report**	To note	Chair	9.45
4.	**Chief Executive & Registrar's Report**	To note	CER	10.00
5.	**Fitness to Practise Report**	To note	D of FtP	10.15
6.	**Finance Update – Management Accounts to October 2024**	To note	D of CS	10.30
7.	**Business Plan 2024 Performance Update**	To note	BPO	10.40
8.	**Strategic Risk Register November 2024**	To approve	CER	10.50
	BREAK (10 mins)			10.55
9.	**Code of Professional Practice**	To approve	D of Dev	11.05
10.	**Business Plan 2025**	To approve	BPO	11.45
11.	**Proposed Budget 2025**	To approve	D of CS	12.00
12.	**Report from the Chair of the Education Committee**	To note	Chair, EC	12.30
	a. Recognition of proposed new programme and satellite programmes	To approve		
	b. Annual Report for 2024 from Education Committee	To note		
13.	**Report from the Chair of the Audit and Risk Committee**	To note	Chair, ARC	12.45
14.	**Report from the Chair of the Remuneration and HR Committee**	To approve	Chair, RemHR	12.50
15.	**Council Work Programme**	To agree	Chair	12:55
16.	**Any Other Business**		Chair	13.00

Close of meeting: 13:00 pm

Date of next meeting: 19 March 2025 (In- person)

General Chiropractic Council

[Unconfirmed] Minutes of the meeting of the General Chiropractic Council On 25 September 2024 by videoconference

Members present	Jonathan McShane (Chair of Council) Keith Walker Paul Allison Catherine Kelly Aaron Porter	Elisabeth Angier Jennie Adams Ralph Pottie Samuel Guillemard Keith Richards
Apologies	Fergus Devitt and Annie Newsam	
In attendance	Nick Jones, Chief Executive and Registrar Penny Bance, Director of Development Joe Omorodion, Director of Corporate Services	Nirupar Uddin, Director of Fitness to Practise Mary Nguyen, Business and Project Officer Rachana Karekar, Governance Coordinator, GCC (minutes)
Observers	Kate Steele, Partner, Capsticks Solicitors	Akua Dwomoh-Bonsu, Professional Standards Authority

1.	**Welcome, apologies and declarations of interest** The Chair welcomed Council members and observers. The Chair welcomed Paul Allison, new registrant member of Council to his first Council meeting further to his appointment with effect from 1 August 2024. Apologies were received from Fergus Devitt and Annie Newsam. Members' interests were captured in the register, published on the GCC website and were accurate. No additional interest was notified.
2.	**Draft minutes of the Council meeting of 19 June 2024 and matters arising** **A. Minutes** Council **agreed** the minutes were an accurate record of the meeting. **B. Matters arising** The Chair confirmed that one matter arising from the previous meeting regarding recruitment of Associate Member of Council was ongoing and will be covered in the meeting.

3.	**Chair's report** The Chair presented the report and congratulated Annie Newsam, Jennifer Adams, Keith Walker, and Elisabeth Angier on their reappointment to Council for a second and final term. The Chair acknowledged the upcoming challenge of replacing Ralph Pottie and Keith Richards. Further noting that the term of the previous independent panel member supporting Council recruitments had ended. An open recruitment process was currently underway for the independent panel member role, which was essential for ensuring that Council appointments meet PSA standards. The CER noted the recruitment exercise aligned with good practice discussed at the PSA seminar earlier this year. Additionally, the Chair advised members that he had approved the candidate pack further to the Council's decision to establish a Council Associate role, with recruitment for this position set to commence shortly, expressing gratitude to Annie Newsam agreeing to join the appointments panel. The Chair noted the intention was to make a two-year appointment with effect from January 2025. The Council **noted** the report.
4.	**Chief Executive and Registrar's report** The Chief Executive and Registrar (CER) presented his report. Council noted the submission of a response to the RCC consultation on lower back pain standard, focusing on consistency and support for regulatory objectives. The CER outlined the presence by the GCC at the annual regulatory event in Scotland, highlighting its importance for regulatory professionals. The CER discussed the report published by Nursing and Midwifery Council (NMC) earlier in the summer regarding their organisational culture, particularly concerning staffing and its impact on performance in fitness to practise. The report described elements of a toxic culture affecting decision-making. The CER reported that the Professional Standards Authority (PSA) had enquired of the GCC (along with other regulators) as to its response to the report and that a comprehensive response had been provided, drawing on evidence from the annual engagement survey and recently concluded organisational review. The CER further noted the organisational review was commissioned as a deeper dive into issues within our fitness to practise area, following requests from the Audit and Risk Committee (ARC) and the Remuneration and Human Resources (RemHR) Committee and that it had been broadened covering all areas.

	The Chair of the RemHR committee affirmed that the Committee had reviewed the report and was able to provide reassurance there were no signs of poor culture or negative relationships within teams or between staff and senior leadership. Council **noted** the report.
5.	**PSA Review of performance 2023 – 24** The Chief Executive and Registrar (CER) presented the report, noting that the PSA conducts an annual performance review with this year's review being a monitoring review. The CER reported that 17 out of 18 standards of good regulation were met. However, concerns were raised about timeliness in the FtP cases. The CER emphasised the report as providing an opportunity for reflection and improvement, highlighting good practice recognised by the PSA, particularly regarding Equality, Diversity, and Inclusion (EDI) efforts as well as the extensive consultation and pre-consultation work related to revisions of the Code of Professional Practice. The CER acknowledged the dedication of staff, partners, committees, and the Council in striving to meet the standards. Council noted the concerns identified in relation to Standard 15, specifically regarding reported staffing issues within the Fitness to Practise (FtP) team. Members urged consideration to these matters, in the light of subsequent papers. Members queried whether the investment in the case management system (CMS) alone was sufficient to improve the core function. The CER emphasised the importance of the case management system and that the business case for it was predicated on creating capacity. Furthermore, he noted that all options to enhance performance were being explored. Council members congratulated the team on achieving 17 out of 18 standards, emphasising the importance of recognising this accomplishment and the significant effort required to reach this level of performance**.** Council **noted** the report.
6.	**A. 1. Regulatory Committee Appointments** The Director of Fitness to Practise (FtP) presented her report. The Director of FtP provided an overview of the regulatory committee appointments. Council noted that Claire Bonnet, overall Chair of the Professional Conduct Committee (PCC) and Health Committee (HC) had resigned. The Director outlined the responsibilities of the overall chair, including bridging the gap between the GCC and independent decision-makers, conducting appraisals, reappointments, recruitment, and training. Following a recruitment process, the Director recommended the appointment

	of Derek McFaull to the new overall Chair role, effective from 1 October 2024 until 3 June 2028. The Director further recommended the appointment of Amanda Orchard and Hannah Poulton as Chair members of the PCC and HC effective from 1 October 2024. Council noted the high calibre of the candidates for the appointments. Council **approved** the appointment of Derek McFaull as the overall Chair of the PCC and HC and appointment of Amanda Orchard and Hannah Poulton to the Chair member role in the PCC and HC. **A.2. Fitness to Practise Update** The Director of FtP provided an operational update, highlighting ongoing staffing challenges within the FtP team due to turnover at the caseworker level. The Director further reported that the risk management group reviewed the situation in August and upgraded the risk related to SR-4 (organisational capacity) from amber to red. The Director updated that the secondment of a senior lawyer for six months benefited the team, and now back to core staff. The Director further provided an update on the performance for the period April to June 2024. Following the concerns raised by Council members as to the FtP staffing issues, the Director explained that a comprehensive review of the team's structure will occur next year, following the implementation of the new CMS. This review aims to identify efficiencies, set realistic targets, and improve workload management. Members discussed the potential benefits of hiring another secondee to help with workload, given the previous secondee's success in managing throughput of cases to the Investigating Committee. The Director clarified that while the previous secondee has returned to their law firm, the option to hire another secondee could be explored, though budget constraints must be considered. Concerns were raised about the volume of section 32 (protection of title) cases. The Director reassured members that these cases are being prioritised and additional resource identified. Members enquired as to the effectiveness of the clinical adviser role and the Director noted the function was working well albeit utilised for simpler cases, with high-risk cases relying on expert advice. The Chair emphasised the Council support for exploring options for supporting staff in delivering the function. The Director reiterated that staff welfare was a priority, highlighting the importance of a balanced approach to resource allocation. Council **noted** the report.

	B. Finance – Management Accounts to August 2024 The Director of Corporate Services (DCS) provided an update on the financial performance for the year to 31 August 2024. The Director reported a headline surplus of £112k for the period, which exceeded the forecast surplus of £73k by £39k. The Director further noted that the projected deficit for the financial year was expected to decrease from the reported £49k to £17k, albeit expected to fluctuate in the remaining months of the year. The Director highlighted that the balance sheet remained strong, with total assets of £3.8 m, including a cash reserve of just under £1m. Members questioned the proportion of overseas students enrolling in UK chiropractic programs and whether it would have an impact on the projected registrant fee income for the year. The Director explained that as seen in the Annual Report not all students on programmes register with the GCC. A steady increase in registrant fee income had been noted over the last few years and the CER added that the registrant fee income was profiled carefully each year within the budget. Council **noted** the report.
	C. Business Plan 2024 The Business and Projects Officer (BPO) provided an update on the performance of the 2024 business plan, reporting progress up to mid-September 2024 on the delivery of five initial projects. The BPO noted that enhancements to the registrant portal was removed as a project due to feasibility concerns and resource constraints and this had been noted by Council following the meeting of Council in June 2024. The BPO noted that of four active projects that remained, three were on schedule and the case management system (CMS) was slightly delayed. The BPO highlighted that 74 submissions had been received to date in response to the public consultation on the Code review, launched in July and set to close on 27 September 2024. The BPO noted the CMS implementation procurement phase had been completed with contract signed. The BPO also reported that the project timeline had been extended with an implementation date of January 2025, rather than December 2024. The BPO highlighted the ongoing campaign to promote CPD submissions and the Code consultation. The BPO acknowledged the recent technical issue experienced with the portal coinciding with the final CPD submission date, for which additional submission time was provided.

	The BPO reported that the near completion of the three-year EDI action plan with a final report summarising outcomes alongside a new EDI action plan would be integrated into the upcoming corporate strategy. Members suggested exploring low-cost improvements to enhance the experience of users to the registrant management system. The BPO confirmed this was a priority with feedback sought. Council **noted** the report.
7.	**Outline Business Plan 2025** The Business and Projects Officer (BPO) provided an update on the development of the next corporate strategy, noting that the current strategy concludes at the end of 2024. The BPO outlined the principal activities included the implementation of the new Code of Practice, embedding the CMS into the FtP process, and developing the new corporate strategy. The CER emphasised the importance of allocating adequate resources to implement the new Code; updating guidance for the Investigating Committee and Professional Conduct Committee and improvements to ways of working, notably in the Fitness to Practise area. Council highlighted the need to find the right balance between regular business-as-usual activities with larger, exceptional projects that arise from year to year such as the implementation of the new Code and IT infrastructure changes. Another Council member pointed out the opportunity for the GCC to enhance the credibility and professionalism of allied healthcare practitioners in response to the challenges faced by the NHS. The CER acknowledged the significance of focusing on integration and that further work needed to be done with the profession. Council members noted that a detailed business plan and budget would be presented to the Council at the December meeting. Council **noted** the report.
8.	**Report from the Chair of the Remuneration and HR Committee** The Chair of the Remuneration and HR Committee provided an overview of the committee's recent activities, expressing appreciation for the support received in his first meeting as Chair. He highlighted key areas of focus for the committee, including a full discussion on the organisational review and forthcoming review of partner service contracts. The CER highlighted that the implications of the Somerville ruling may prove to be more wide reaching than initially thought and that further work was underway on this.

	Council **noted** the report.
9.	**A. Report from the Chair of the Education Committee** The Chair of the Education Committed presented the update report to the Council, following the Committee's meeting on 11 July 2024. **B. MCC Madrid Education Programme Approval** The Chair of the Education Committee summarised the report, highlighting the recent panel visit to Madrid, noting the panel found the proposed satellite programme as having good facilities and was well-run. The Committee Chair clarified that the programme was the same as the approved programme offered by MCC in the UK, albeit at a different campus, a common model in healthcare. The Council noted the **report** and **approved** the satellite chiropractic degree programme in Madrid subject to the conditions outlined in the GCC Approval Panel's report.
10.	**Council Work Programme** The Council reviewed and **noted** the work programme and meeting dates for 2025.
11.	**Any other Business** There were no items of other business. The Chair thanked members for their contributions.
	Date of next meeting: 5 December 2024 via MS Teams.

General Chiropractic Council

Agenda Item: 02b

Subject: Matters Arising from 25 September 2024

Presenter: Jonathan McShane, Chair GCC

Date: 5 December 2024

Item	Actions	Update
No matters arose from the last meeting(s)		

General Chiropractic Council

For noting

Chair's report

Meeting paper for Council on 05 December 2024

Agenda Item: 03

Introduction

1. A fundamental task of the regulator is establishing standards. Last time I reported that our Education Standards had been implemented across the sector. Soon after our last meeting, in September, the consultation on our revised Code of Professional Practice concluded and since then the team have been conducting a careful and thorough evaluation of the many responses received.

2. We are grateful for the thoughtful submissions received and they have shaped the version you are asked to consider at this meeting. By the time the Code is implemented it will have been 10 years since the current Code was introduced. This seems like an appropriate interval and my expectation is that the proposed Code before us will stand the test of time in a comparable way.

3. Like many organisations, we find the financial climate a challenging one. We continue to absorb increases in costs, with ongoing efficiencies and modest increases in our income. I am committed to continue to work within a financially disciplined way so that we do not face the need to increase fees. We will need to scrutinise our expenditure on an ongoing basis, innovate where we can, and ensure we derive good value from our investments – that for several years we have needed to top-up our income. We will be exploring these issues further today and over the next few months emphasising the importance of robust financial management.

Governance matters

4. I am grateful for Members' cooperation during November in ensuring their availability and for their preparation for the annual appraisal process and which contributed to the smooth conduct of the appraisal process. All appraisals have now been completed.

5. Further to agreement by Council to proceed with the appointment of an Associate Member role at the last meeting I am delighted to report that following open recruitment and interviews we have offered the role to two strong candidates. I

am grateful to Annie Newsam for joining me on the Appointments Panel and commend the thoroughness in ensuring the effectiveness of the process undertaken. The appointments are for a two-year term, effective from January 2025. Whilst the post-holders will not have voting rights on Council matters, they can play an integral role in shaping discussions, providing input, and contributing their expertise, from their own perspectives.

6. We have commenced a new recruitment round for two Council vacancies arising in July 2025 – for a lay and registrant member, including a member for Scotland. I am grateful to Aaron Porter and Elisabeth Angier who have agreed to join the panel for the upcoming recruitment round.

7. I confirm that Paul Allison has agreed to join the Remuneration and Human Resource Committee. I am grateful to him and for the patience of the Chair and members of the Committee as we worked to bring the Committee back to full complement, which it now is.

8. Finally, following an open recruitment exercise we have appointed an 'Independent Panel Member' to support Council and Committee recruitment campaigns in the future. Paul Grant was selected for the role and has confirmed his acceptance.

Engagements (virtual unless stated)

- 03 October: Meeting with Dr Anne Wright CBE, Chair of General Optical Council (GOC).
- 12 October: Attended the British Chiropractic Association (BCA) annual conference Chiro Live 2024 at Hilton St. George's Park (In-person).
- 23 October: Visited Isis chiropractic centre in Milton Keynes at the invitation of Jatinder Benepal (In-person).
- 4 November: Attended a meeting with the GCC Investment managers.
- 4, 5,11 and 12 November: Met with Council members to conduct annual appraisal review.
- 11 and 18 November: Council Associate Programme shortlisting and interviews.
- 19 November: Attended the GCC Remuneration and HR Committee meeting.
- 28 November: Visited London South Bank University **(**LSBU) Croydon Campus (In-person).

Jonathan McShane

Chair

General Chiropractic Council

For noting

Chief Executive & Registrar Report

Meeting paper for Council on 5 December 2024

Agenda Item: 04

Purpose

This regular report summarises key developments in the period since the Council last met, on 25 September 2024, not covered elsewhere on the agenda.

Recommendations

Council is asked to note this brief report.

General update

1. Our staff team is now at full complement with all recent recruitment complete. The final quarter of the year has seen significant activity in all aspects of work, demonstrating some impressive achievements – notably the development of the Code of Professional Practice (later in the agenda); implementation of the case management system; a buoyant education application pipeline; and managing core activity well, such as in Fitness to Practise, governance and registration.
2. The Registration team, supported by colleagues, are currently handling retention (a busy period in the calendar) and so far the process has been seamless with lessons from previous rounds all implemented. Last time, I reported some glitches on the last weekend of the CPD submission period, with a short extension was granted to those affected, and I am pleased that the process concluded positively. A small number of registrants have been contacted to revisit their submissions where these were evaluated as deficient.
3. We are also making a difference on dealing with the build-up of S.32 ‘title’ cases, supported by additional resource. We hope to have dealt with the majority of cases by year-end.

Memorandum of Understanding (MoU) for investigating healthcare incidents where suspected criminal activity may have contributed to death or serious life-changing harm

4. We are signatories to a forthcoming MoU setting out how healthcare organisations, regulatory bodies (including the GCC), investigatory bodies and prosecutorial bodies in England will work together in cases where there is suspected criminal activity by an individual in relation to the provision of clinical care or care decision making.

5. It covers incidents occurring in the course of healthcare delivery where suspected criminal activity on the part of an individual is believed to have led to or significantly contributed to the death or serious life-changing harm (whether of a physical or psychological nature) of a patient or service user. Such events of course are rare. On occasion, we are contacted by police further to their investigation on matters where a registrant may be involved and this MoU will ensure we continue to work cooperatively on such matters.

World Federation of Chiropractic Global Education Conference 2024

6. The 12th WFC Global Education Conference was held between 30 October and 2 November 2024 in Kuala Lumpur, Malaysia. This year's conference theme, Innovation and Technology: Shaping the Future of Chiropractic Education, reflected the critical shifts we are witnessing as education embraces new technological frontiers to prepare chiropractors for a dynamic healthcare landscape. The conference provided an unparalleled opportunity for educators, practitioners, researchers, regulators and students to exchange knowledge, explore innovative ideas and forge connections that will shape the future of chiropractic care.

7. Penny Bance (Director of Development) and Daniel Moore (Education Committee) were invited to present research conducted by the GCC, and provide the final Keynote address of the conference, focused on the development of contemporary Education Standards that meet the needs of a constantly evolving healthcare sector. Our contribution was very well received.

Professional Health and Social Care in Scotland Regulatory Event 2024

8. The Professional Health and Social Care in Scotland Regulatory Event 2024 took place in Glasgow on 6 November 2024. Its focus was on the theme "The Role of Regulation in the Workforce of the Future" covering topics such as upstream regulation, regulatory reform, and continuous professional development.

9. With the GMC and General Osteopathic Council, we led a session on *Protecting patients, supporting professionals* drawing on our experience this year in developing the Code of Practice. And with other Chief Executives I spoke on a panel about our hopes for a reformed professional regulatory landscape. This including the need for a

Regulatory reform

10. There are no material developments further to my recent reports as to the prospects of reform granting the GCC new powers. As previously noted the focus of the Department of Health and Social Care (DHSC) has been in relation to the GMC obligations to register Physician Associate and Anaesthesia Associate roles, with effect from 2025. Further, to work to extend powers more widely affecting the GMC, NMC and HCPC. That is likely to be the focus during this Parliament. Any material developments will be reported to Council.

11. Notably, the DHSC on 26 November 2024 published a consultation on options for regulating NHS managers, a manifesto commitment, to introduce professional standards for, and regulate, NHS managers in England. The consultation closes on 18 February 2025. Amongst other things it highlights there will likely be a need for one or more new or existing bodies to take responsibility for all or part of a regulatory system – including standard setting; holding a register and a disbarring scheme. Whilst peripheral to our activities, we may respond from our experience of regulating a small profession.

Professional Standards Authority (PSA)

12. The PSA has spent some time exploring the potential benefits of establishing a common code of conduct applicable across different types of health and care professions. The stated aim was to help retain staff, support multi-disciplinary working, improve workplace culture, and ensure consistency in regulatory decision-making while reducing complexity in the system.

13. Research undertaken found that, though there are advantages to having one code of conduct across health and care professions, it would not necessarily reduce complexity. There was also a risk that a common code would need to be diluted to cover so many and varied professions. This view was further reinforced by conversations with other stakeholders, including several of the regulators who expressed concerns about the practicalities around implementing a common code and a recognising the differences between professions. This was our position.

Change NHS

14. The Government has indicated that it is developing a 10-year plan for the NHS, and has committed to co-develop the plan with the public, staff and patients through a detailed engagement exercise. It wants the public and health and care staff in England to share their views, experiences and ideas at the Change NHS online portal.

15. As a body established by statute our responsibilities are set out therein. We have a duty to develop the profession and we may wish to make a short submission

outlining the opportunities presented by a regulated workforce given ongoing workforce pressures. Equally, that task is of central concern to the profession and I understand that professional bodies are preparing detailed submissions along these lines.

Meetings and engagements

September 2024

- 24 September – Clinical placement strategy development session

October 2024

- Webinar interview Academy of Physical Medicine (CPD event)
- 10 October – Health and Social Care regulators' Forum hosted by CQC
- 24 October – CEORB – Chief Executives of Regulatory Bodies monthly meeting

November 2024

- 6 November – Scottish Regulatory Conference – Edinburgh
- 7 November – Audit and Risk Committee of the GCC meeting
- 15 November – Forum of Deans bi-annual meeting chaired by the RCC
- 19 November – Remuneration and HR Committee of the GCC meeting
- 21 November – Education Committee of the GCC meeting
- 22 November – CEORB - Chief Executives of Regulatory Bodies monthly meeting
- 26 November – GMC symposium on the future of education and development

Nick Jones

Chief Executive & Registrar

General Chiropractic Council

For review and noting

Fitness to Practise update

Meeting paper for Council on 5 December 2024

Agenda Item: 05

Purpose

This Fitness to Practise report provides Council with an update on the following:

i. Operational update
ii. Fitness to Practise performance report

Recommendations

Council is asked to note this update

i Operational update

Staffing issues / internal resources

1. As reported to Council previously, following turbulence in the FtP team due to staffing issues all roles have now been filled with the remaining Caseworker role appointed in November.

2. In order to address capacity issues within the team, (contributed to by the inexperience of the new team members) and to ensure the team has access to experienced support whilst the FtP Manager & Investigator are released to work on the implementation of the Case Management System additional measures have been taken. We outsourced a batch of cases to our lawyers to reduce the caseload of the team. Further, a senior lawyer seconded to the FtP team earlier this year would return for a further period of secondment one day a week from December until end of January 2025 to support case progression on high-risk cases.

3. Further to these steps the risk management group at its meeting in November 2024 downgraded the assessed risks at SR4 from red to amber as reported to the November meeting of the Audit and Risk Committee.

CMS Projects:

4. In line with the 2024 business plan, we are implementing a case management system (CMS) for FtP activity. As noted previously, this is a significant undertaking in 2024 in any event, especially in view of the ongoing staffing issues within the team.

5. Implementation is progressing well with the bulk of the work involving the FtP Manager (the subject matter expert) reviewing and signing off requirements. *A more detailed update on the CMS project can be found in the Business Plan 2024 update paper (Item 7).*

ii Fitness to Practise performance report

1. This section provides Council with an update on the operational performance of the FtP team in the latest completed quarter, the period July to end of September 2024 (Q3).

Performance report summary

Detail on the five key areas of performance summarised below is at Annex 1, with glossary of terms at Annex 2.

Performance of the team in Q3 was impacted due to the issues noted above. We continue to take a risk-based approach in managing incoming complaints.

i. *New enquiries:* We keep an eye on this as a significant increase here could affect performance as was the case with 'advertising' in the past. There are 30 enquiries which are open, an increase from 13 as reported in March and June, steadily increasing to 20 reported at the last quarter. This is because of the teams focus on the recruitment and onboarding of new members of the team as well as prioritising formal complaints which are high risk.

ii. *New complaints:* A higher-than-expected level of incoming *complaints* was received in Q3. In September, ten complaints were received (against the usual circa. four per month). That said, there were 60 open complaints at the end of Q3, compared to 74 reported to Council in September for Q2. This is significant achievement by the team (with 24 cases determined by an Investigating Committee) reflecting the hard work of the team and the additional support committed; and is the lowest since October 2023.

    As highlighted previously, there has been a lower number of referrals made from the Investigating Committee to the Professional Conduct Committee for a hearing to be held (five referrals as opposed to nine predicted for the end of Q3). This has had the effect of easing financial pressure in Q3 and Q4 2024 as referrals made in the second half of the year are normally scheduled in 2025 – albeit being felt in 2025.

iii. *Interim suspension hearing* (ISH): There were no ISH hearing held in the period. This remains a key focus for the team and despite the staffing issues, we continue to deal with high-risk cases promptly, an important consideration in safeguarding and for the PSA in assessing how quickly we manage risk.

iv. *PCC hearings:* Five substantive hearings were scheduled in Q3 with four concluded due to one adjournment which has been relisted to December 2024. The end-to-end median for Q3 was 106 weeks – an increase of one week from Q2. Our performance in listing cases is shown in table 8 and we see that cases referred in 2024 are being listed more quickly than previously – with good prospects for reducing the end-to-end median performance.

v. Our performance in managing s.32 (protection of title) complaints in this period has remained below expected standards with 44 cases relating to 34 individuals and the median time to close complaints up to this period was 41 weeks. A temporary member of staff joined in October and is now making good progress on managing these complaints.

My observations for the end of the year are that we are likely to take forward a larger number of complaints (c.70) into 2025 than we did in 2024 (66). The number of incoming complaints has continued to increase in November with December still unknown. I expect the overall impact on timeliness to be impacted as we continue with our approach of focusing on higher risk cases rather than close newer, lower risk cases.

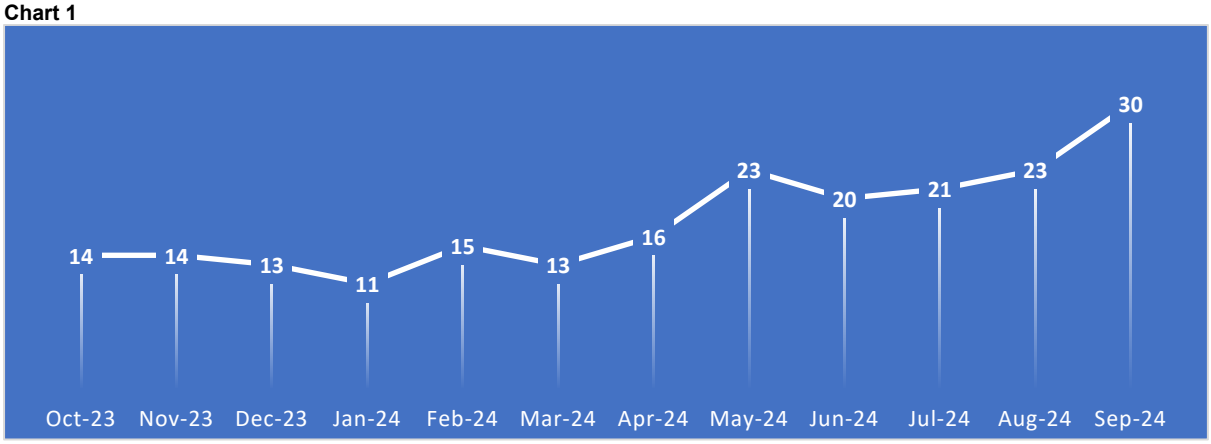
6. Detailed commentary on the above five areas of performance is at Annex 1 with glossary of terms at Annex 2.

05: Annex 1: Performance report

A. Enquiries

Open enquiries in last 12 months

Chart 1



There are 30 enquiries that are open, albeit two relating to advertising concerns. Typically, a small number of enquiries tend to be escalated to a formal complaint.

Total number of enquiries closed/promoted in 2023/24

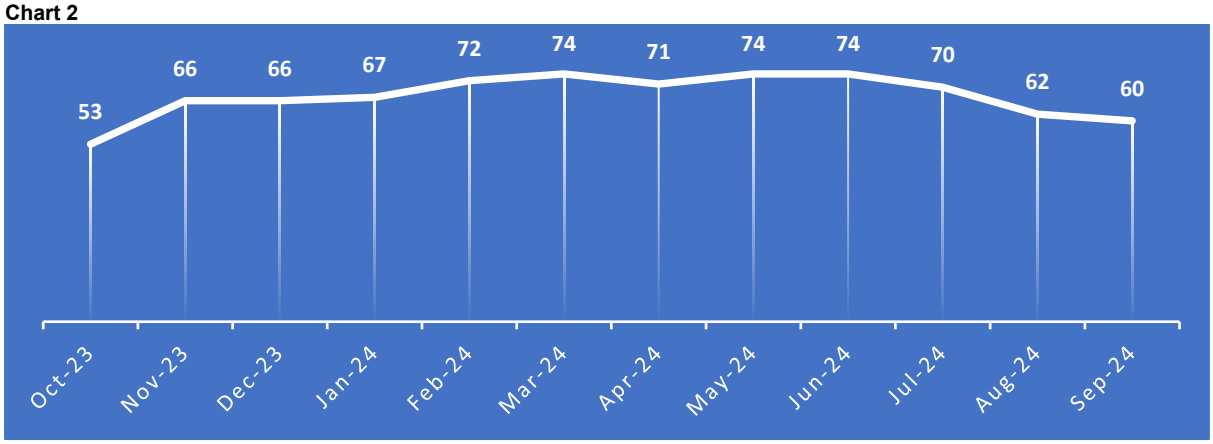
Table 1

	2023	2024		
	Q4	Q1	Q2	Q3
Closed with no further action	6	6	5	5
Promoted to s.20	3	3	1	1
Total closed	**9**	**9**	**6**	**6**

B. S.20 (IC) Complaints in 2024

Total number of complaints carried forward and activity by month in 2023/24

Chart 2



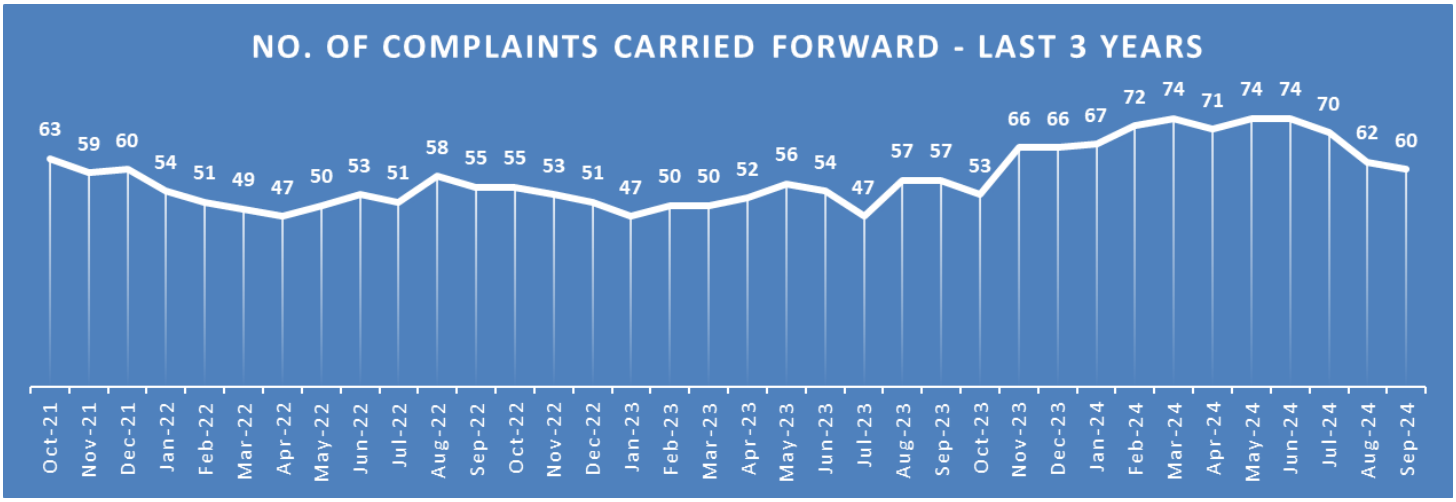
We continue to prioritise case management of higher risk complaints, which by their nature are usually long-standing complex complaints.

Table 2	Oct -23	Nov -23	Dec -23	Jan -24	Feb -24	Mar -24	Apr -24	May -24	Jun -24	Jul -24	Aug -24	Sep -24
New s.20 complaints in (no.)	9	4	6	5	3	3	4	6	1	5	5	10
Cases determined (no.)	4	2	5	3	2	2	5	4	2	8	8	8

A higher number of cases were determined in Q3 compared to January – June 2024.

The additional support and focus on cases then led to 24 cases determined by the IC in Q3. There has since been a focus on the implementation of the case management system and we expect case progression to slow in the last quarter of 2024.

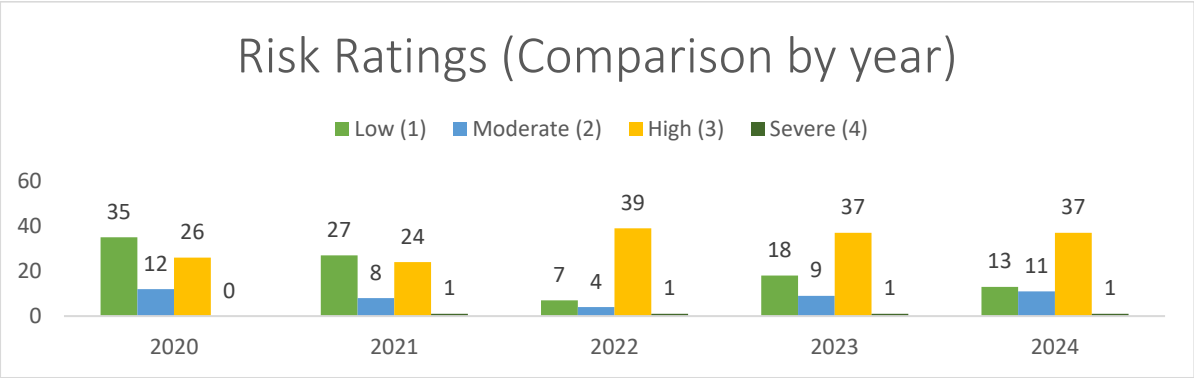
Chart 3



The number of open complaints (60) as at the end of Q3 is the lowest it has been since October 2023, due to the effort by the team to conclude 24 cases in Q3 following the period of secondment. A higher than usual number of complaints were received in October and November which will affect the next reporting period.

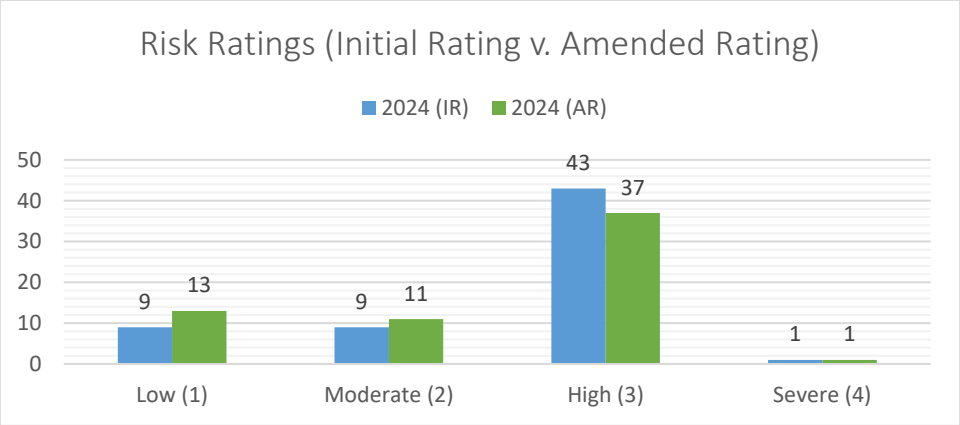
Risk rating of open IC complaints

Chart 4



When assessing and categorising risk we take the complaint at its highest (as advised by our internal auditors), resulting in more cases being categorised as *high risk* initially but allows for the rating to be amended or reduced as further evidence emerges.

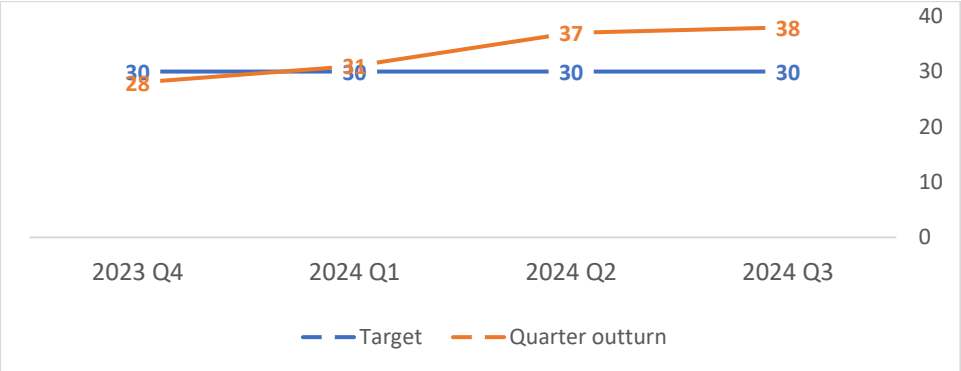
Chart 5



Even after adjustment, 61% of complaints are high or severe risk. Such complaints take longer to investigate.

Time complaints have been open: median weeks

Chart 6



The median time of open complaints increased one week to 38 weeks in Q3 (from 37 weeks in Q2)

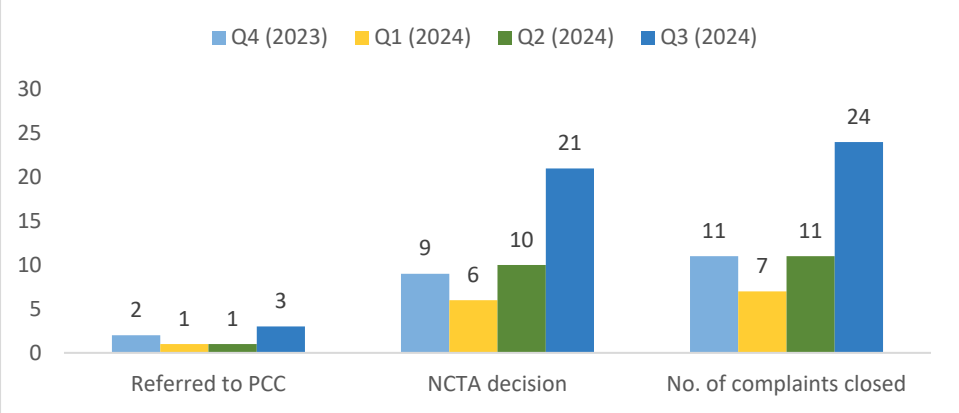
Breakdown of open current complaints

Table 3	2023	2024		
	Q4	Q1	Q2	Q3
Under 52 weeks	57	58	49	44
52 weeks +	7	15	23	13
104 weeks +	1	2	2	3
153 weeks +	0	0	0	0

Three cases were open of over 104 weeks, of which two are third party investigations (an Inquest and criminal matter) and a further subject to reconsideration by the IC and since closed.

Number of complaints closed by the Investigating Committee in 2023/24

Chart 7

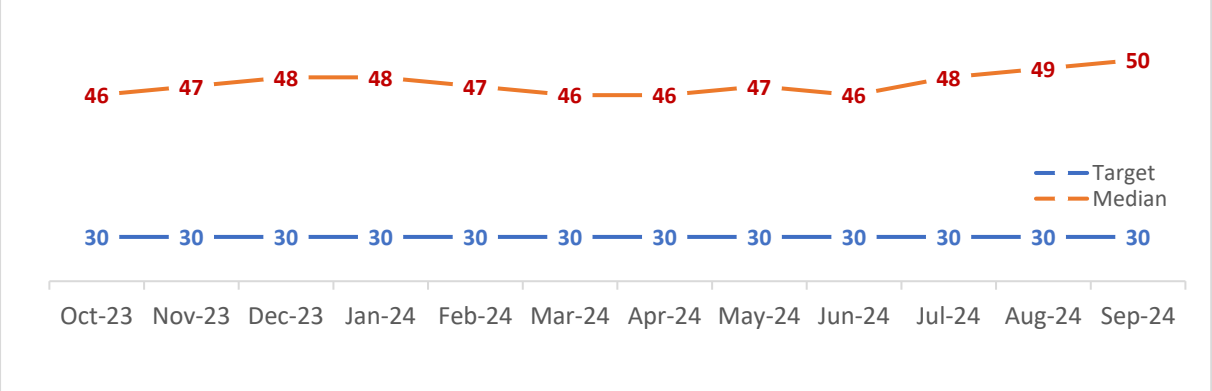


Of the 24 complaints closed in Q3, 24 were closed as 'no case to answer' and three were referred to the PCC. The volume of complaints closed is the highest it has been since Q1 2022 where the IC closed 21 cases. In terms of referral to PCC, we estimate and budget on the basis of one referral a month from the IC, and borne out in Q3.

Median time taken to close cases in last 12 months

(Time taken from the opening of a complaint to closure (either by a decision of no case to answer or referral to PCC) by the Investigating Committee)

Chart 8



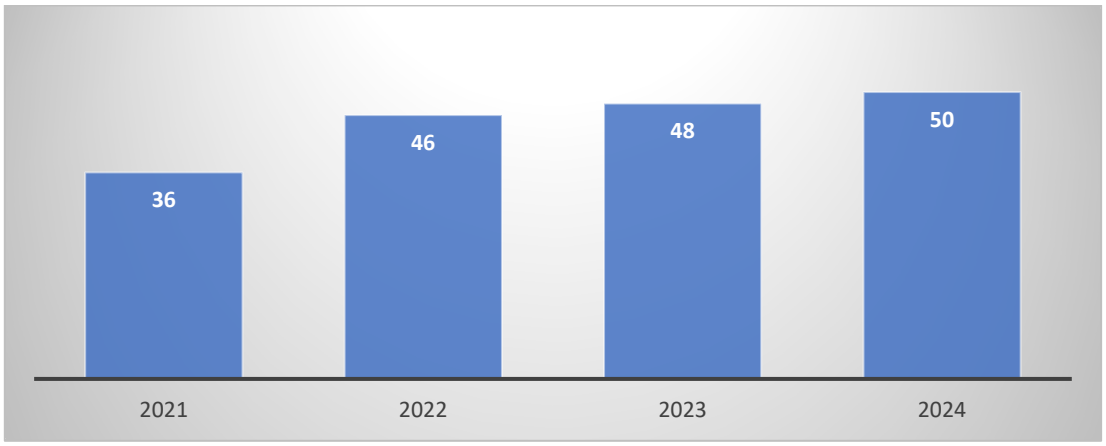
Median times have remained between 46 weeks to 50 weeks for the last 12 months. Our assessment is that the median will only start to shift if we close newer cases.

However, it is important to note we continue to prioritise the complex high-risk cases (which by the nature are likely to be older cases) and with a higher number of older cases being determined by the IC in Q3 the time to close reflects that.

Further to investment in the case management system; a contingency to address any future staffing turnover; and a stable staffing team we look forward to shifting that picture in 2025 with a view to returning to 2021 levels.

Median time taken to close cases – by calendar year

Chart 9



The median at the close of Q3 2024 ended at 50 weeks.

C. Interim Suspension Hearings

Table 5

	2023 / 2024											
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
ISH hearings	0	1	0	2	2	0	0	1	0	0	0	0
Suspension imposed	0	0	0	0	0	0	0	0	0	0	0	0
Suspension not imposed	0	1	0	1	2	0	0	1	0	0	0	0

Consideration of matters where an interim suspension may be necessary are an unpredictable area, affecting outputs from both the FtP team and the IC. There was no IC interim suspension hearing (ISH) held in Q3.

In 2021, the median time (from the date there is enough information received indicating risk, to the date of the ISH) was 4 weeks. In 2022, this increased slightly to 5 weeks. In 2023, the median was 3 weeks, and this was the same up to Q3 for 2024. As there was no ISH held in Q3, the median has remained the same and an important consideration in safeguarding and for the PSA in assessing how quickly we manage risk.

D. Professional Conduct Committee

Number of cases referred from the IC; and heard by PCC in 2024

Table 6

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	July-24	Aug-24	Sep-24
No. of PCC cases b/f	11	11	10	10	10	8	8	8	8	7	7	7
No. of Referrals from the IC	1	0	1	1	0	0	0	0	1	1	1	1
PCC hearings held	2	1	1	2	2	1	1	0	2	1	1	2
Part heard	1	0	0	1	0	0	1	0	0	0	0	0
PCC Cases Closed	1	1	1	1	2	0	0	0	2	1	1	1

Decisions of PCC cases concluded in 2024

Table 7

Decision	Number
Removal from Register	0
Suspended	0
Conditions of Practice Order	1
Admonishment	2
No UPC	5

The decisions of the PCC in 2024 are in line with decisions made in previous years.

Open PCC cases: Listing progress

There were 7 open PCC cases open at the end of Q3 of 2024. The target established is that on referral from the IC, the hearing should be listed before the PCC within 35 weeks. The median from IC outcome to PCC outcome is 43 weeks at the end of Q3 of 2024. That said, performance for cases referred in 2024 is encouraging and we remain optimistic that this will reduce the 'end-to-end' median.

Table 8

Case	Date referred from IC	Date listed for hearing	Weeks	Status
Case 1	21/03/2023	07/10/2024	80	Target for listing met but case adjourned in October 2023 and was relisted for 2024 as Registrant applied for postponement to obtain further evidence. Hearing went part heard in October 2024 and has been relisted for five days in January.
Case 2	17/10/2023	30/09/2024	49	Target not met as parties not ready / required further time to prepare case for hearing. (Now concluded)

Case 3	06/12/2023	12/12/2024	53	Target for listing met but hearing went part heard in July and has been relisted for 1 day in December.
Case 4	18/06/2024	11/12/2024	25	Target met
Case 5	17/07/2024	24/02/2025	32	Target met
Case 6	14/08/2024	Not yet listed		
Case 7	18/09/2024	Not yet listed		

Of the 7 cases awaiting PCC hearing none were referred prior to 2023. Three were referred in 2023 and four in 2024.

Our ability to meet targets of cases shown above is affected by:

- availability of the parties and or witnesses
- parties not ready / requiring further time to prepare case for hearing
- adjournments outside of the control of the GCC

E. Section 32 cases

Our target this year is to continue to close a section 32 complaint within 16 Weeks of opening.

The median time taken to close section 32 cases in 2024 (as at Q3) was 40.5 weeks, as result of priority been given to urgent / high risk s.20 matters as well as focus on CMS as noted in the *Operational Update*.

As noted above in the summary, a dedicated additional resource has been obtained for section 32 cases and good progress is being made to investigate these cases with a view to close as many as possible before the end of the year.

Table 11

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Number of cases (at beginning of the month)	16	17	20	24	31	37	38	40	43	45	49	55
Number of new cases in a month	1	3	6	7	6	3	2	3	2	4	6	2
Number of cases closed in period	0	0	2	0	0	2	0	0	0	0	0	2

Niru Uddin
Director of Fitness to Practise

05: Annex 2

Glossary

CA 1994	The Chiropractors 1994
Complaint / S.20 (IC) Complaint	An allegation (complaint) under Section 20 of the CA 1994, made against a chiropractor, to the effect that: a) he has been guilty of unacceptable professional conduct; b) he has been guilty of professional incompetence; c) he has been convicted of a criminal offence; or d) his ability to practise is seriously impaired due to a physical or mental condition. S.20 complaints are formal complaints. The GCC's target to refer a matter to the IC is 30 weeks.
CTA	Case to answer decision by the IC (which are referred for hearings before the PCC). The GCC's target to list the matter for a hearing once referred by the IC is 35 weeks.
Enquiries	Under section 20 of the CA 1994, the GCC can only deal with an allegation (complaint) against a registered chiropractor where the complaint relates to fitness to practise matters. The GCC uses the term 'Enquiry' to describe any professional conduct communication containing information which may amount to an 'allegation' or 'complaint' under the Act however there is insufficient information to open as a s.20 complaint. As such, these are pre formal complaint communications.
IC	Investigating Committee
ISH	Interim Suspension Hearing
ISO	Interim Suspension Order
NCTA	No case to answer decision by the IC
PCC	Professional Conduct Committee
Promoted enquiries	The GCC will assess the information received initially as an enquiry to determine whether sufficient information has now been received to open as a s.20 complaint. Where it is opened as a s.20 complaint, the date promoted relates to the date this changed from an enquiry to a s.20 complaint

Quarter 1	Jan – March
Quarter 2	April – June
Quarter 3	July – Sept
Quarter 4	October – December
Risk Rating	A risk assessment is carried out on receipt of a complaint by the by the GCC and given a risk rating to capture the seriousness of the case. • Risk Rating 1: Low risk: (No unwarranted risk of harm and or issues have been addressed) • Risk Rating 2: Moderate risk: (Treatment resulted in injury, conduct was not persistent and/or deliberate, issues have been addressed) • Risk Rating 3: High risk: (Unwarranted risk of serious harm including inappropriate clinical care, inappropriate conduct, incompetence or abuse of trust including sexual misconduct or power imbalance concerning vulnerable patients (including those with mental health issues). Issues complained of remain in place, there is an ongoing risk to patients / public from the chiropractor's clinical practice / behaviour, conduct is persistent and / or deliberate) • Risk Rating 4: Severe risk: (Sexual misconduct. Life may be in danger, risk of major injury or serious physical or mental ill health. The conduct is increasing in frequency and/or severity) The risk rating above of complaints might lead to a referral for a hearing to consider interim suspension of a registrant's registration.
S.32 Complaint	Section 32 of the CA 1994 creates a criminal offence for a person who is not registered with the GCC describing themselves as a Chiropractor (also known in other regulatory bodies as protection of title or illegal practise cases). Our target for timeliness from receipt to closure or next steps decision point (16 weeks).

General Chiropractic Council

For review and noting

Finance Update - Management Accounts to October 2024

Meeting Paper for the Council Meeting on 05 December 2024

Agenda Item: 06

Purpose

The purpose of the management accounts is to report financial and non-financial performance to-date compared to the set budget or forecast by Council for the same period. This is intended to assist Council and the Executive to exercise effective oversight, allow scrutiny of the GCC's finances and management controls.

This report outlines the performance against the forecast income and expenditure targets for the period to 31 October 2024. The Executive reviews the management accounts each month and takes necessary corrective actions to manage material deviations from the set financial targets.

Recommendations

The Council is asked to note this report.

Introduction

1. The management accounts pack is comprised of the:

    - Summary of income and expenditure account for the period to 31 October 2024 – and commentary on material variances (Annex 1a and 1b)
    - Balance sheet as of 31 October 2024 (Annex 2), and
    - Recommendations.

Summary of income and expenditure account for the period to 31 October 2024 – and commentary on material variances

2. The table below shows the actual year-to-date (YTD), full year Dynamic, fixed Forecast for the year and full year Budget results for the 2024 financial year.

£'000s	A YTD Actual	B YTD Forecast	C YTD Variance	D Full Year Dynamic 2024	E Full Year Forecast 2024 [Fixed]	F Full Year Budget 2024 [Fixed]
	£	£	£	£	£	£
Income	2,753	2,763	-10	3,253	3,256	3,332
Expenditure	2,515	2,643	128	**3,343**	**3,305**	3,259
Headline Surplus /-Deficit	**238**	**120**	118	-90	-49	**72**
Underlying Surplus /-Deficit	229	110	119	-80	-40	82

3. The realised headline surplus for the period is £238k (column A of the table), compared to the headline forecast surplus of £120k (column B) for the same period. This represents an over-achievement of the forecast surplus for the period by £118k.

4. The total variance between the actual and forecast income and expenditure for the period is shown in column C. Column C shows a net positive variance of £118k (i.e. a negative income YTD variance of £10k and positive expenditure variance of £128k). The detailed statement of income and expenditure account, variance analysis threshold and the reasons for the variance are provided in Annexes 1a and 1b.

5. The headline full year fixed forecast deficit for the year is £49k (column E). The headline dynamic deficit is £90k (column D) – representing an increase in the fixed deficit amount of £41k by the year-end.

6. The dynamic forecast tracks how we expect to perform against the fixed annual forecast by the end of the financial year. It also responds to the question, *'what surplus or deficit do we expect to realise at the year-end?'.*

Balance sheet as of 31 October 2024

7. The balance sheet at Annex 2 shows a total net assets value of £3.894m (December 2023: £3.401m). This is represented by the general, designated, restricted and revaluation reserves.

The cash at bank as of 31 October 2024 is £1,005k (December 2023: £2.280m). This shows a headline cash ratio of £0.59 that is available to settle every £1 of our short-term liabilities. The headline ratio, which is below the standard level of at least £1/£1, does not present a solvency issue because the adjusted ratio (i.e. after allowing for fees paid in advance) is £0.77/£1.

8. The value of the investments increased by £233k (5.1%) from £4.535m as of 31 December 2023 to £4.768m on 31 October 2024. The unrealised investment gain (i.e. paper gain) in the period is £255k (December 2023: paper gain of £96k).

Recommendations

The Council is asked to note this report.

Joe Omorodion
Director of Corporate Services

Annex 1a – Commentary variances in the statement of income and expenditure for the period to 31 October 2024

Year-to-date variance analysis threshold policy

1. The Audit and Risk Committee (ARC) agreed a £10k variance analysis threshold policy from January 2021.

2. Where income or expenditure varies by £10k or more in the period under review a commentary on the variance is to be provided. Other items below the variance analysis threshold are to be noted on a risk and materiality basis and considered as immaterial for control and monitoring purposes.

3. In the Variance column of the report, this icon  shows that the variance amount is positive. That is, the actual income variance is more than the target level of income in the period and expenditure is under the expected level. This icon  is the reverse.

   This directional symbol  shows a downward movement on key items on the balance sheet page of the report; the upward icon  indicates an improved position.

4. Applying the £10k variance analysis threshold, the following comments are provided on the income and expenditure variances in the period.

Commentary on YTD income variance

5. The breakdown of the total income variance is shown in the *Report by Income & Cost Centre* section of this report at Annex 1b.

6. The total income earned in the period to-date is less than forecast income by £10k. This is mainly driven by shortfalls in both *Initial Registration* (Practising) and *Restoration* fee income.

   a. **Registrant Fees Income – Initial Registration, Practising (-£7k):**
      - Income from new registrants is less than the forecast in the period by £7k. We had expected to receive fee payments from 229 applicants but received from 220.

   b. **Restoration Fees Income (-£7k):**
      - Income from restoration fees is £7k less than the forecast. We planned to receive income from 28 applicants in the period but received from 21 (i.e. 18 practising and 3 non-practising).

   c. **Other Income (+£4k):**

- This is largely made up of the bank interest earned on a money market deposits (i.e. a positive variance) of £4k.

Commentary on YTD expenditure variance

7. The breakdown of the total expenditure variance is shown in the *Report by Income & Cost Centre* section of this paper at Annex 1b.

8. The total forecast expenditure for the period is **under-spent by £128k** (a positive variance). This is made up of the following under/over-spent forecast lines of £10k or more.

Over-spent budget lines by £10k or more:

No.	Budget Item	Variance (£)	Variance commentary
1.	Shared Central Costs (Technology cost centre)	-16k	The negative variance is mainly due to the completion of essential work related to retention renewals on the GCC Registration portal. This includes retention renewals activities, archiving, Direct Debits/Sage Pay payments, CPD, and Indemnity Insurance.
2.	Investigating Committee (IC)	-£10k	The over-spend is due to legal fees associated with pre-Investigating Committee (IC) cases. By the end of the year, however, we expect the total forecast costs for the pre-IC outsourced work on 25 cases, (17 existing and 8 new cases) to be in the region of £192k. This reflects an increase of £137k over the original forecast amount of £55k for the year.
3.	Governance Costs (Council cost centre)	+£15k	This is due to an over-provision made for the PAYE Settlement Agreement (PSA) liability for the 2023/24 tax year. The liability is made up of the tax and NIC contributions due on the Council members' business-related travel and accommodation costs in the year, along with under-spend in Council development day costs.
4.	Human Resources Costs (HR cost centre)	+£20k	Under-spend is mainly due to the: • unused forecast amount for the organisational review work and • receipt of a credit notes for the cancellation of the staff training portal agreement (following a switch to another provider)
5.	Corporative Services cost centre	+£27k	The actual costs incurred in implementing the Welsh Language Standards compliance order is

			less than we had planned. Hence, the under-spend here.
No.	**Budget Item**	**Variance (£)**	**Variance commentary**
6.	Professional Conduct Committee (PCC)	+£79k	This forecast line is driven by the number of hearings held in any given period. This under-spend in the period is due to having fewer actual hearing days (of 64) compared to the forecast hearing days (of 75) in the period Jan-Oct-24.
7.	Interim Suspension Hearing (ISH)	£13k	This forecast line is driven by the number of hearings held in any given period. We had 3 actual hearing days compared to the 10 that we planned for the period Jan- Oct-24.

General Chiropractic Council

October 2024 Management Accounts

Overview - Statement of Income and Expenditure Account

Annex 1b

	MONTH October				YEAR-TO-DATE (YTD) October 2024				Full Year FIXED FORECAST 2024	Full Year DYNAMIC FORECAST 2024	Full Year BUDGET 2024
INCOME	Actual	Forecast	Variance	Var %	Actual	Forecast	Variance	Var %			
	£	£	£		£	£	£		£	£	£
Registrant fees	252,454	260,604	-8,150	-0	2,546,742	2,559,191	-12,449	0%	3,029,501	3,017,755	3,119,800
Investments	10,000	10,000	0	0	100,000	100,000	0	0%	120,000	120,000	120,000
Test of Competence (ToC)	4,000	4,000	0	0	70,000	70,000	0	0%	72,000	78,000	70,000
Other Income	-320	250	-570	-2	36,044	33,522	2,522	8%	34,023	36,964	21,850
TOTAL INCOME	**266,134**	**274,854**	**-8,720**		**2,752,786**	**2,762,713**	-9,927		**3,255,524**	**3,252,719**	**3,331,650**
EXPENDITURE											
Governance costs[1]	10,266	10,179	-87	-0	119,597	134,432	14,835	11%	166,145	143,314	160,818
Shared Central costs[2]	68,546	79,924	11,378	0	768,322	797,701	29,379	4%	984,725	965,236	998,957
Fitness to Practise (FtP)[3]	98,100	136,010	37,910	0	1,123,767	1,209,792	86,025	7%	1,436,609	1,514,572	1,411,618
Development costs[4]	61,033	54,052	-6,981	-0	502,862	500,900	-1,962	0%	717,187	718,955	688,005
TOTAL EXPENDITURE	**237,945**	**280,165**	**42,220**		**2,514,548**	**2,642,825**	128,277		**3,304,666**	**3,342,077**	**3,259,398**
Underlying Operating Surplus / -Deficit					228,238	109,888	118,350		- 39,142	- 79,358	82,252
HEADLINE OPERATING SURPLUS / -DEFICIT	**28,189**	**-5,311**	**33,500**		**238,238**	**119,888**	**118,350**		**-49,142**	**-89,358**	**72,252**
Percentage	*11%*	*-2%*	*13%*		*9%*	*4%*	*4%*				
GAINS/-LOSSES ON INVESTMENTS					**254,757**						
SURPLUS / -DEFICIT BEFORE TAXATION					492,995						

NOTES ON EXPENDITURE CATEGORIES

1. Council, ARC and RemCo
2. CER, Technology, HR, Finance and Property
3. Investigations, IC, PCC, ISH and Protection of Title
4. Policy, QA, Test of Competence (ToC), Communications and Education Committee
7. Budget 2024 – as agreed by Council in Dec-23
5. Fixed Forecast 2024 – will be received by Council in Jun-24
6. Dynamic Budget / Forecast 2024 – tracks performance against the Budget or Forecast

General Chiropractic Council
October 2024 Management Accounts
Report by Income & Cost Centre

Annex 1b

			MONTH				YEAR-TO-DATE (YTD)				Full Year FIXED FORECAST 2024	Full Year DYNAMIC FORECAST 2024	Full Year BUDGET 2024
			October				October 2024						
Detailed Income Statement	Dept		Actual	Forecast	Variance	Var %	Actual	Forecast	Variance	Variance			
			£	£	£		£	£	£	%	£	£	£
Income	72	Initial Regn Fees - Practising	16,500	23,250	-6,750	*-29%*	165,000	171,750	-6,750	*-4%*	171,750	165,000	171,750
	72	Initial Regn Fees - Non-practising	100	0	100	*100%*	800	700	100	*14%*	700	800	600
	72	Retention Fee- Practising	232,987	232,987	0	*0%*	2,332,275	2,332,273	2	*0%*	2,798,251	2,798,254	2,887,200
	72	Retention Fee- Non Practising	2,117	2,117	-0	*0%*	21,267	21,568	-302	*-1%*	25,800	25,501	26,600
	72	Non- Practising to Practising	0	0	0	*0%*	13,600	12,000	1,600	*13%*	12,000	14,400	10,400
	72	Restorations	750	2,250	-1,500	*-67%*	13,800	20,900	-7,100	*-34%*	21,000	13,800	23,250
		Total Registrant Fees	252,454	260,604	-8,150		2,546,742	2,559,191	-12,449		3,029,501	3,017,755	3,119,800
	74	ToC Income	4,000	4,000	0	*0%*	70,000	70,000	0	*0%*	72,000	78,000	70,000
	33	Investments	10,000	10,000	0	*0%*	100,000	100,000	0	*0%*	120,000	120,000	120,000
	33	Other	-320	250	-570	*-228%*	36,044	33,522	2,522	*8%*	34,023	36,964	21,850
		Total Investments & Other	13,680	14,250	-570	*-4%*	206,044	203,522	2,522		226,023	234,964	211,850
		TOTAL INCOME	**266,134**	**274,854**	**-8,720**	**-0**	2,752,786	2,762,713	-9,927	**0%**	**3,255,524**	3,252,719	**3,331,650**
Governance Costs	10	Council	10,266	10,179	-87	*-1%*	117,613	132,542	14,929	*11%*	162,995	140,071	157,428
	11	Audit & Risk Committee	0	0	0	*0%*	1,290	1,290	0	*0%*	1,590	1,590	1,830
	12	Remuneration Committee	0	0	0	*0%*	693	600	-93	*-16%*	1,560	1,653	1,560
		Total Governance	10,266	10,179	-87		119,597	134,432	14,835		166,145	143,314	160,818
CER Office Costs	30	CER's Office	15,082	15,277	195	*1%*	149,421	149,904	483	*0%*	180,007	179,528	180,170
Shared Central Costs	31	Technology	11,955	10,697	-1,258	*-12%*	163,425	147,049	-16,376	*-11%*	169,818	196,079	175,970
	32	Human Resources	2,951	11,504	8,553	*74%*	46,018	65,889	19,871	*30%*	97,154	77,288	89,858
	33	Corporate Services	25,949	30,473	4,524	*15%*	274,347	301,280	26,933	*9%*	380,227	353,292	395,320
	34	Property	12,609	11,973	-635	*-5%*	135,111	133,578	-1,533	*-1%*	157,519	159,049	157,639
		Total Shared Central Costs	68,546	79,924	11,378		768,322	797,701	29,378		984,725	965,236	998,957
Fitness to Practise Costs (FtP)	50	FtP Team	30,308	33,305	2,997	*9%*	428,406	435,765	7,359	*2%*	502,375	500,111	401,215
	51	Investigating Committee	26,802	38,849	12,047	*31%*	229,224	219,622	-9,602	*-4%*	260,492	406,320	203,683
	52	Professional Conduct Committee	37,406	60,024	22,618	*38%*	449,578	528,597	79,018	*15%*	640,989	566,172	743,632
	53	Interim Suspension Hearing	0	3,832	3,832	*-100%*	12,639	25,474	12,835	*50%*	32,418	19,583	41,908
	54	Protection of Title	3,585	0	-3,585	*100%*	3,920	335	-3,585	*-1071%*	335	22,385	21,180
		Total FtP	98,100	136,010	37,910		1,123,767	1,209,792	86,025		1,436,609	1,514,572	1,411,618
Development Costs	70	Development Team	31,098	28,527	-2,571	*-9%*	289,310	286,882	-2,428	*-1%*	465,519	467,953	407,618
	73	Quality Assurance	6,766	6,206	-560	*-9%*	43,977	44,252	275	*1%*	61,222	60,947	77,549
	74	Test of Competence	3,151	2,850	-301	*-11%*	58,334	58,896	562	*1%*	61,895	61,134	55,665
	75	Policy and Development	20,018	16,469	-3,549	*-22%*	105,021	104,773	-248	*0%*	120,952	121,200	137,622
	13	Education Committee	0	0	0	*0%*	6,220	6,098	-122	*-2%*	7,599	7,721	9,551
		Total Development	61,033	54,052	-6,981		502,862	500,900	-1,962		717,187	718,955	688,005
		TOTAL OPERATING COSTS	**237,945**	**280,165**	**42,220**	**15%**	2,514,548	2,642,825	128,277	**5%**	**3,304,666**	3,342,077	**3,259,398**
		Underlying Operating Surplus / -Deficit					228,238	109,888	118,350		- 39,142	- 79,358	82,252
		HEADLINE OPERATING SURPLUS / -DEFICIT	**28,189**	**-5,311**	**33,500**		238,238	119,888	118,350		**-49,142**	**-89,358**	**72,252**
		Percentage	*11%*	*-2%*	*-13%*		*9%*	*4%*	*4%*		*-2%*	*-3%*	*2%*
		GAINS/-LOSSES ON INVESTMENTS	**254,757**				**254,757**						
		SURPLUS / -DEFICIT BEFORE TAXATION	**282,946**				492,995						

GCC Balance Sheet
As at 31 October 2024

Annex 2

	31 December 2023		31 October 2024		Movement	% Change
Fixed Assets	£	£	£	£		
Tangible Assets	0		26,993			
Investments	4,535,256		4,767,825			
		4,535,256		4,794,818	259,562	6%
Current Assets						
Debtors	50,568		43,336			
Bank	2,280,429		1,005,397			
Total Current Assets		2,330,997		1,048,733	-1,282,264	-55%
Current Liabilities						
HMRC and pensions	40,037		47,413			
Payments in advance	2,821,350		470,208			
Trade creditors	79,644		65,140			
Corporation tax payable	46,023		31			
Other creditors	290,974		1,197,461			
Total Current Liabilities		3,278,027		1,780,253	-1,497,774	-46%
Current Assets less Current Liabilities		-947,030		-731,521		
Total Assets less Current Liabilities:		3,588,227		4,063,298	475,071	13%
Long Term Liabilities		187,145		169,222	-17,923	-10%
Total Assets less Total Liabilities (Net Assets)		**3,401,082**		**3,894,076**		
Funds of The Council						
General Reserve	1,629,701		1,629,701			
Designated Reserve	1,158,983		1,158,982			
Restricted Reserve	27,049		27,049			
Revaluation Reserve	585,349		585,349			
Gains/(Losses) on Investments	0		254,757			
Surplus/(Deficit) on Operating Activities	0		238,238			
Total Funds/Reserves		**3,401,082**		**3,894,076**	492,995	14%

General Chiropractic Council

For noting

Business Plan 2024 Update

Meeting paper for Council on 5 December 2024

Agenda Item: 07

Purpose

The Council sets the GCC strategic priorities and ensures the necessary resources are available for them to be delivered.

This paper provides an update on our performance against the 2024 Business Plan so that Council can scrutinise progress and be assured that progress is being made in meeting its strategic objectives and risks to delivery and budget.

Recommendations

Council is asked to **note** the report.

Background

1. Council agreed the 2024 Business Plan in December 2023, along with the five projects to be delivered this year.

2. This is the third and final year of the three-year strategy 2022-24. Progress as to delivery of the business plan is reported to Council at each meeting.

Business Plan Performance Summary

3. This is the final performance report on the 2024 Business Plan to Council this year, covering the period to 25 November 2024. Over the last three years, we business plans aiming to deliver the overarching strategy. It was important to be ambitious, but we also had to find the 'right' balance of projects and business activities where necessary.

4. This year was no different. Much of it involved large-scale activities including the review of the Code of Practice, the implementation of a case management system for Fitness to Practise and enhancing the current registrant management system (iMIS) together with a set of other activities. In the light of capacity, we

scaled back our ambitions relating to the registrant management system - although some enhancements were made.

5. The mix of projects and business activities are summarised below:

Projects	***Business activities***
• Review of the Code of Practice • Fostering professionalism and safer care • Case management system for Fitness to Practise • Enhancements to the registrant management system (iMIS) • Development of the GCC Corporate Strategy	• Implementing actions further to new Education Standards and arrangements for quality assurance • Recruiting our Council membership • Recruiting to the Investigation Committee and Professional Conduct Committee • Recruiting to Education Committee • Completing the 15-point EDI action plan

6. Further to the Business Plan projects outlined above we achieved the following:

- The GCC met 17 of the 18 Standards of Good Regulation by the Professional Standards Authority (PSA)'s annual performance review.
- Developed the new Code of Practice and launched a public consultation over the summer and held various engagement sessions with key stakeholders including patients, registrants and Council and Committee members – and present the final version today.
- Published toolkits on Managing Patient Data and Candour for registrants.
- Completed a tender to procure a case management system for Fitness to Practise and made significant progress towards its implementation.
- Incorporated a Welsh version of the initial registration application form.
- Supported all the UK chiropractic programme providers with implementing the new Education Standards (2023). As of September, every student studying an approved UK degree programme in chiropractic will be studying against the 2023 version.
- Appointed the new Chair of Council in January 2024.
- Appointed a registrant member of Council in September 2024.
- Appointed the overall Chair of Investigating Committee and Professional Conduct Committee in September 2024.
- Appointed a lay member of the Education Committee in July 2024.

- Appointed a lay independent member panel member to support our recruitment of members to serve on our Council, Committees and panels.
- For the first time, introduced a Council Associate Programme, offering development and leadership experience.
- Produced several Fitness to Practise learnings, covering subjects including professional communication and co-operating with an investigation. All learnings can be found here.
- Hosted a workshop for chiropractic educational providers in September 2024, providing a discussion as to how the profession can support the use of clinical placements in chiropractic education.
- Commissioned independent patient research to better understand the patient's perspective about professional behaviours so that we can support registrants to establish and maintain professional boundaries.
- Reviewed and launched an enhanced 'Becoming a Chiropractor' section of our website aimed at education providers, current and future students.
- Completed the 15-point EDI action plan.
- Set the 2023/2024 CPD for registrants on focusing on EDI, providing resources to support registrants to reflect and complete their CPD records.
- Continued to promote the 'I'm Registered' mark, increasing awareness of regulation and registration.

7. Of the five projects, the end of year summary is as follows:

- 1 – Project (**Enhancements to iMIS**) was removed from the Business Plan due to the unviability of its delivery. We have been making incremental improvements instead and will continue to do so. Inclusion as a headline in the business plan was, in hindsight, a detail too far.
- 1 – Project (**Code of Practice**) is complete, subject to approval. The new Code of Practice will be presented to Council later in this meeting for approval.
- **Fostering Professionalism**: Subject to the approval of the new Code of Practice, the new toolkit for imaging and updated and expanded guidance and a toolkit on professional boundaries will be published in early 2025.
- **Case Management System**: Timescales adjusted and scheduled for launch in January 2025
- **GCC Corporate Strategy 2025 – 30**: We plan to consult on our proposals in the New Year.

8. There are five annexes to this report:

- **Annex A** displays summary information on progress made in delivering the projects in the 2024 business plan.

- **Annex B** provides a more detailed commentary on the status or progress of each of the projects. The status of each project is assessed against the agreed measures (e.g. Key Performance Indicators, KPIs, Project

Schedule Variance, PSV, and Milestones) in the business plan.

- **Annex C** provides a detailed progress report on the implementation of the CMS to date.

9. A summary of communications activity in line with our Plan for 2024 is at **Annex D**.

10. An annual report on the activities relating to equality, diversity and inclusion is at **Annex E**.

Mary Nguyen

Business and Projects Officer

Annex A: Business Plan 2024 Dashboard, 25 November 2024

This dashboard presents BP 2024 projects' progress, priority level, external impact and risk of not delivering them in the current financial year. The order in which the projects are listed is according to their project number.

Annex A: Business Plan Dashboard				
No.	**Project**	**Status and % Completion**	**RAG Rating** GAW[1]	**External Impact**
1	**Review of the Code of Practice**	**On schedule**		High
	Key milestones: March, June, September, December 2024	100%		
2	**Fostering professionalism and safer care**	**On schedule**		High
	Key milestones: March, April, October, December 2024	60%		
3	**Case Management System for Fitness to Practise**	**On schedule**		High
	Key milestones: March, April, July, September and October 2024	60%		
4	**Enhancements to the registrant management system (iMIS)**	**Removed as BP**		High
	Key milestones: June, September, November and December 2024	10%		
5	**Development of the GCC Corporate Strategy**	**Started**		High
	Key milestones: June, September, November and December 2024	10%		

Annex B – Business Plan 2024 Projects

No.	Project	Measures (KPIs, PSVs, milestones)	Progress (November 2024)
1	**Review of the Code of Practice**	**2024 Deliverables and Milestones** 1. Share framework with Council **March 2024** ✓ 2. Draft Code of Practice and consultation strategy presented to Council for approval **June 2024** ✓ 3. Revised Code of Practice public consultation **July - Sept 2024** ✓ 4. Analysis of consultation responses and revised Code of Professional Practice presented to Council for approval **December 2024** **Project Targets** 1. By end of 2024, the revised Code of Professional Practice is approved by Council, for design and publication in 2025, and implementation in 2026 as required by legislation.	**Status: On Schedule** **Project Update:** 1. Appointed a contractor for this project in January 2024. A project timeline has been produced highlighting key activities/milestones throughout the project. Steering Group meetings convened on 18 January and has since met monthly. 2. A draft structure of the Code and proposed values were shared with Council on 20 March 2024. 3. Developed a communications plan to ensure ongoing engagement and involvement up to June. 4. Formed a subgroup of the Education Committee members as the Education Committee has delegated responsibility for the Standards of Proficiency of chiropractors. The subgroup has met three times. 5. The Code Conversation continued with monthly newsletter articles and over 400 responses were received to Registrar's blog in the March 2024 newsletter. 6. Pre engagement conversations were held with Council and the Professional Associations in April, and two online and an in-person meeting with registrants in May. A report of those Code Conversations has been produced. 7. Council considered and approved the draft Code of Professional Practice, consultation document and EIA. 8. A consultation communications plan was finalised along with the documents for consultation in English and Welsh,

No.	Project	Measures (KPIs, PSVs, milestones)	Progress (November 2024)
			online survey and promotional materials. Focus groups and webinars scheduled. 9. The public consultation launched on 22 July 2024. 120 responses have been received. 10. A 'drop in' session for registrants, a BCA session with over 200 attendees, 2 UCA sessions and focus groups with the IC and PCC Chairs, education providers, RCC, Professional Associations, and expert witnesses have been held. 11. An external company has been commissioned to support the analysis of the online consultation responses and focus groups and produce a report. 12. The consultation closed on 27 September 2024. 116 responses were received plus four written responses from the PSA, BCA, UCA and GMC. 13. A meeting to engage staff from the FtP team was conducted on 29 October. 14. The GCC Code Consultation feedback report has been produced and shared with the Steering Group. 15. Council members attended one of two sessions held on 4 and 8 November 2024 to discuss three key themes that had emerged from the consultation analysis. 16. Additional Steering Group meetings have been scheduled throughout November to finalise the draft Code ahead of December Council.
		2024 Deliverables and Milestones 1. Published toolkit on managing patient data**. Nov 24**✓	**Status: On Schedule – though order of delivery has changed due to the Code Review**

No.	Project	Measures (KPIs, PSVs, milestones)	Progress (November 2024)
2	**Fostering professionalism and safer care**	2. Published toolkit on diagnostic imaging for registrants with imaging equipment ~~**Nov 24**~~ **will be Q1 2025** **3.** Published revised guidance on maintaining boundaries ~~**October 2024**~~ **– will be Q1 2025** 4. Published toolkit for registrants on maintaining sexual boundaries, informed by patient research. ~~**December 2024**~~ **– will be 2025 following on from the guidance** **Project Targets** 1. By end of 2024, to have published GCC resources (e.g. guidance, toolkits etc) on key themes identified in our regulatory activities.	**Project Update:** A Managing Patient Data toolkit has been published. The referral toolkit for imaging has been delayed while the Code has been drafted. The Boundaries guidance and toolkit are likely to be strengthened by increased focus within the new Code of Practice, so will be developed further in light of the Code review in early 2025. An online forum and focus groups with 36 patients on professional boundaries in July will inform the Code and revised Guidance and a toolkit. Research report received from Community Research and patient report being prepared for publication.
3	**Case management system for Fitness to Practise**	**2024 Deliverables and Milestones** 1. Produce a formal request for proposal (RFP) for the case management system (CMS) including vendor shortlisting, supplier presentations and selection of preferred supplier. *(Process estimated to take 3 months).* **January - March '24** ✓ 2. Appointment of a supplier contract negotiation. *(Process estimated to take 1 month).* **September '24** ✓ 3. Implementation including user training ~~and loading of historic data (for stats comparison).~~ *(Process estimated to take 3 months).* **August – December '24** 4. Complete Data take-on (intake of current case data) **January '25** 5. Go live with a fully populated system. **January '25**	**Status: On schedule (with new delivery time)** **Project Update:** The tender process was completed in May 2024 and a preferred supplier was identified. The costs were above those when the initial budget was proposed to Council in 2023 and a business case was presented to Council in July 2024. Council approved the business case to proceed with the preferred supplier. Development of the project commenced in July 2024 and is progressing well. The Subject Matter Expert (the FtP Manager) has largely been involved to ensure the end-to-end journey of the investigation process is accurate.

No.	Project	Measures (KPIs, PSVs, milestones)	Progress (November 2024)
		Project Targets By the end of 2024, implement a case management system to the Fitness to Practise process	The GCC team will undertake User Acceptance Testing in December 2024. An important stage as it ensures that the system meets the needs and requirements before release. Additionally, a complete data migration of open cases will be undertaken in January 2025. At this stage, the system is on schedule to go-live in January 2025. Annex C provides a detailed progress report on the project.
4	**Enhancements to the registrant management system (iMIS)**	**2024 Deliverables and Milestones** ~~1. Meet with the developer to formalise the project plan and scope of works required **January 2024**~~ ~~2. Council will receive an update at its meetings in **March and June 2024**~~ 3. Implement a Welsh application form on the registrant access portal **June 2024** ✓ **Project Targets** ~~By the end of 2024, iMIS (CRM system) will have integrated the additional requirements.~~ ~~By June 2024, initial registrant applications will be available in Welsh.~~ ~~By October 2024, changes will have been made to the CPD form to better support registrants logging their development.~~	**Status: Removed as BP project** **Project Update:** This project has been removed as a Business Plan project. In consideration of the staff resources absorbed for the review of the Code, and the financial implications affected by the case management system procurement process, it was agreed that this project would become a business-as-usual activity with incremental improvements being made.

No.	Project	Measures (KPIs, PSVs, milestones)	Progress (November 2024)
5	**Development of the GCC Corporate Strategy**	**2024 Deliverables and Milestones** 1. Development of Strategy with Council **June 2024** ✓ 2. Consultation strategy presented to Council for approval ~~**September 2024**~~ **March 2025** 3. Public consultation on draft Strategy with key stakeholders including patients, public and registrants ~~**Oct – Nov**~~ **2024 Jan-March 2025** 4. Final version presented for approval. ~~**December 2024**~~ **March 2025** **Project Targets** 1. Corporate Strategy is approved by Council ~~**December 2024**~~ 2. Corporate Strategy is published on the website ~~**January 2025**~~	**Status: On schedule** **Project Update:** The development of the Corporate Strategy commenced on 18 June 2024 – at a full-day development session with Council. The Executive will take in the key discussions and themes addressed to carry out pre-consultation engagement with stakeholders Oct-Dec 2024. A development plan will be presented to Council for discussion at its December meeting.

Annex C - Implementation of the case management system (CMS)

Project Overview

1. This project aims to implement a new Fitness to Practise (FtP) case management system to become a single source of truth for General Chiropractic Council (GCC) FtP concerns and cases from the point that a concern is raised through to investigation outcome.

2. Following a procurement process during the spring, the GCC awarded Fortesium the contract to deliver a customised Fitness to Practise Case Management solution. Fortesium have a Commercial Off-the-Shelf (COTS) FtP Solution that requires customisation and some elements of bespoke development have also been agreed as part of this implementation. Bespoke elements include enhancements to bundling functionality, third part access developments to cover access for IC panel members, registrants, solicitors and auditors, dual case ownership functionality and MFA functionality.

3. The project includes 3 key phases: Discovery and requirements gathering, Configuration and bespoke development and testing. As shown in the project plan later in this report, phases will run concurrently in line with an agile approach to make the best use of the resources available and complete the implementation as soon as possible.

Current Status

4. The project has made good progress in line with the project plan since the last project update.

5. We remain on track to go-live on 21 January 2025 with a slight delay of 1 day compared to the go-live date reported in September. This is due to a decision taken to manually input data relating to open investigation cases as this represented the best use of resources and lowest cost while offering the best outcome in terms of data quality and change management.

6. The Fortesium team are in the final stages of configuration work with around 5% of the process map still to be completed. Integration and bespoke development work are well underway and User Acceptance Testing (UAT) preparation session have taken place to enable the GCC team to begin UAT.

7. Penetration testing is schedule to take place W/C 6 January 2025 which will allow any vulnerabilities identified to be resolved before real user data is inputted the following week.

Key Accomplishments during the reporting period

- A number of short discovery sessions have taken place to gather remaining requirements

- Work packages of draft user stories have been shared in sets with assigned priority which has streamlined the review and sign off process allowing the project to keep pace with the plan. The dedication of the subject matter expert (the Fitness to Practise Manager) 1-2 days per week has been useful to ensure signed off work can be continually fed to the configurators.
- Configuration work on the main workflow and anytime tasks is 95% complete
- System testing is 45% complete
- Bespoke development work is 60% complete
- Integration work has commenced now that the iMIS test environment has been established and is in the early stages but on track to be completed in line with the project plan
- Confirmed decision regarding data migration/input – after considering all options and costs it was agreed that conducting full team data input sessions would be the best course of action, this will include input of all data points, documents and emails relating to open investigation cases taken forward into 2025. Three back-to-back sessions are planned beginning Monday 13 January 2025. No historic data will be migrated.
- UAT preparation session took place on 20 November 2024 – the Fortesium Lead Test Analyst provided an overview of the best way to conduct testing, tools to use and how to raise bugs/defects.
- A demo of the bespoke bundling and redaction functionality was provided on Friday 22 November to ensure the developments will meet the team expectations and allow the opportunity to tweak requirements if required.

Upcoming Milestones and Deliverables

- Final discovery sessions will be completed W/C 25 November to gather requirements around witness statements, referral to ASA, file review process and the use of DocuSign
- Data reporting requirements to be gathered W/C 25 November
- Data input preparation/training session is scheduled to take place on 6 December with the Fitness to Practise team
- Additional test resource will be assigned to the project to complete all system testing by mid-December
- UAT will begin, and effort assigned to resolve any defects arising from this
- External penetration testing will be conducted by the GCC's preferred provider during the W/C 6 January 2025 – Fortesium Tech team will be on standby all week to resolve any critical or high vulnerabilities identified
- Data input sessions will be completed 13 – 15 January 2025
- Go-live 21 January 2025
- Handover to support and assign a Customer Success Manager

Risks and Issues

8. A project risk register has been drafted and is being maintained by the Fortesium Project Manager. No new risks have been raised that require additional action at this time.

9. It should be noted that while the project remains on track to go-live on the date planned, there remains no contingency in place so the impact of any unforeseen team absences or capacity challenges will have an impact on the timeline. Fortesium have taken steps to mitigate the impact of any such challenges within the configuration and development team. The GCC project team review competing priorities at their internal weekly meeting, balancing between the business-as-usual Fitness to Practise work and this project.

GCC/Fortesium
December 2024

07: Annex D – Communications Update

1. Overview of channels

Newsletter

Since January 2024, 4303 registrants have appeared on the newsletter mailing list (this figure includes the addition of new registrants, and the removal of those who are no longer registered). The current mailing list is 4246. Only 27 currently registered individuals have unsubscribed from the list (two remain on the register as they are under FTP investigation).

The open rate of the newsletter is extremely high, with each registrant opening an average of 70.5% of the newsletters they were sent. Only 248 registrants did not open any of the newsletters they were sent, but this is heavily skewed by new graduates, who have only been sent one or two newsletters.

Due to the relatively low click rate (2203 of all recipients did not click any link in the newsletter during 2024) the newsletter now contains more information on each story, meaning it is less important that the user clicks through to the website

Website

The website is averaging 2800 users per week, with 33,694 searching the register a total of 128K times.

X/Twitter

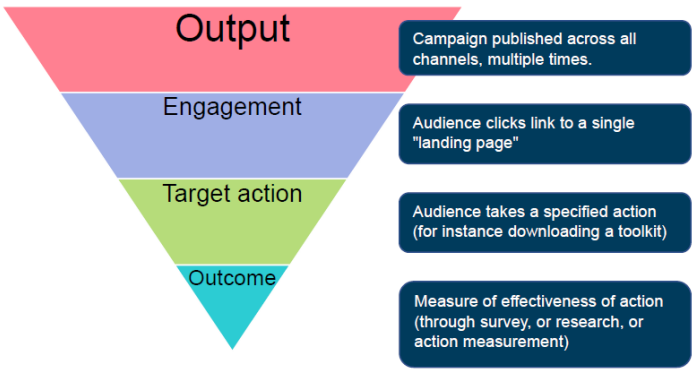
The GCC no longer considers Twitter to be a key channel. Changes to the platform in the past year have meant that it no longer fulfils a useful role in promoting the work of the council. We maintain a presence but it is no longer updated or monitored.

LinkedIn

LinkedIn has grown as an effective channel throughout 2024 with 1217 followers on the platform (an increase of 309 since December 2023).

2. Impacts of Specific Campaigns

The communications plan, presented to Council at its June 2023 meeting, introduced the message funnel approach to understanding not only the communications output, but (where possible) the impact of that output on targeted outcomes.



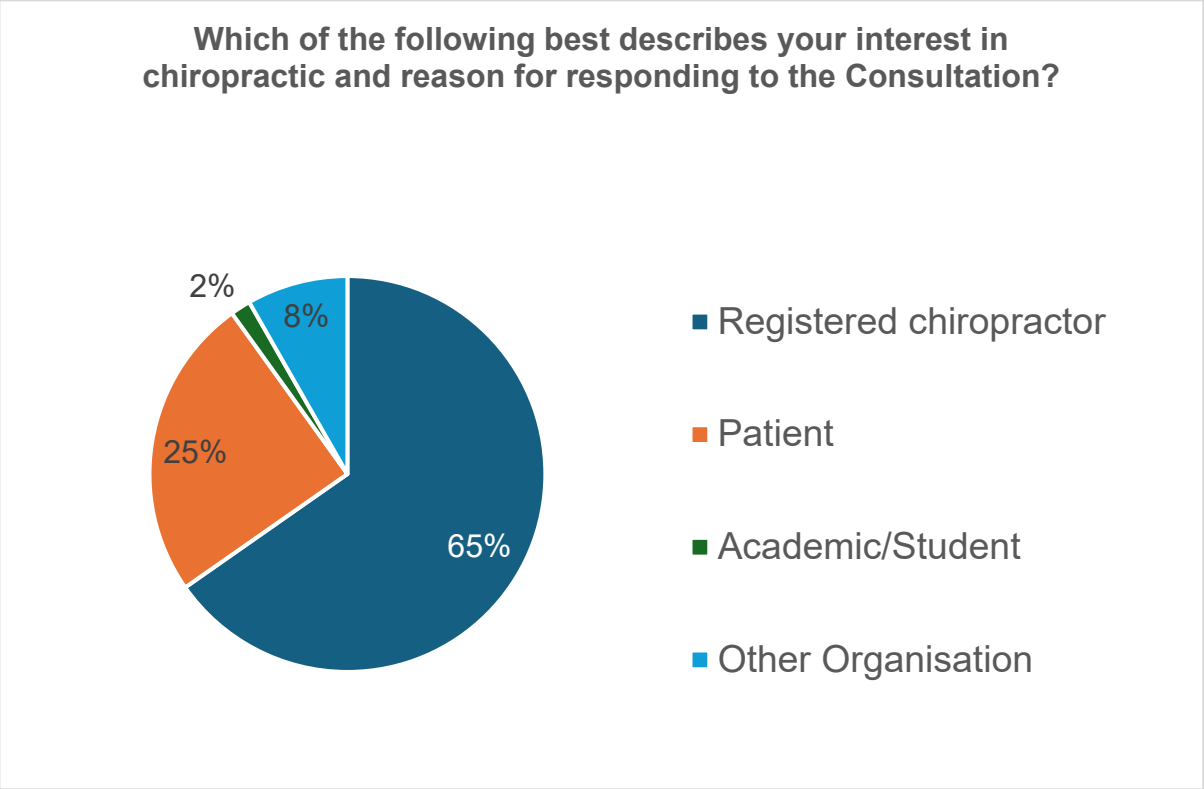
In this annex we look at two of the big communications projects of the last year through that model to understand their impact.

a) Encouraging participation in the Consultation Questionnaire

Here we consider the activity that supported the completion of the Code of Professional Practice Consultation Questionnaire. The activity had two main aims – to encourage completion of the questionnaire, and to encourage chiropractors to share the consultation with their patients and colleagues.

Output	• The Code Consultation Landing page was visited 1338 times during the Consultation period.
	• The webpage included:
	  ○ The Code of Professional Practice (downloaded 304 times)
	  ○ The Consultation Guide (downloaded 108 times)
	  ○ Equality Impact Assessment (downloaded 52 times).
	• 3789 registrants and prospective registrants were invited to join the consultation by email. The email included links to a personalised letter for colleagues and a personalised letter for patients to be passed on to help promote the consultation. Education providers were sent a letter for students in the final year. These personalised letters were downloaded a combined total of 382 times.
	• Links within the email newsletter related to the Code Consultation were clicked a total of 231 times.

Engagement	• Of the 3789 invitation emails sent to chiropractors, 2907 were opened at least once (75% open rate) and 294 recipients clicked one of the links (7.6% click rate - either direct to the questionnaire, or to the website). Of the further 11 invitations sent to stakeholders, 51 (46%) were opened and links were clicked in 18 (16%). • The link to the questionnaire from the website was clicked a total of 91 times during the consultation period (this is only able to be tracked when the user accepts cookies). • The questionnaire was visited a total 622 times during the consultation period from 516 different IP addresses (approximately equivalent to different devices). The questionnaire could be closed and revisited later – and we were able to “retarget” 60 users who had started, but not completed, the questionnaire with one week to go. Only one of the 60 retargeted contacts completed the questionnaire.. • By sharing the personalised letters and links, three individuals were responsible for 124 of the 622 total visits to the questionnaire – however only 17 of these 124 visits resulted in completed questionnaires (15 of these self-reported as patients, one as a chiropractor and one as a student).
Target Action	• A total of 121 responses completed responses were received to the consultation. 116 of these were via the questionnaire and 5 were sent as separate documents (all from organisations rather than individuals). • A total of 30 completed responses were received as a response to the personalised patient letter. • A total of 52 completed responses were received as a response to the personalised letter to registrants.

Outcome	We are please with the number of completions of the questionnaire by both chiropractors and patients, and the overall completion rate compares very well with similar exercises completed by other healthcare regulators.  It is important to note that the consultation also included three well attended events hosted by the Professional Associations.

Conclusions and learning

The number and quality of the responses to the consultation was welcome and compares well with similar exercises run by other healthcare regulators. The participation of so many patients was particularly gratifying.

The poor response rate for students was likely a result of the time of year (it was run during the summer holidays and while we have evidence that the personalised letters were shared by the education establishments, these only converted to two responses from students).

The disappointing response rate from colleagues of chiropractors requires more exploration. There is less evidence that the personalised letters and materials were shared, and sadly no completed responses were received from colleagues.

b) Pulse Survey – understanding the profession.

The Pulse Survey is an ongoing measure of issues and challenges within the profession, to understand the trust the profession has in the GCC's role, and to be able to rapidly spot and respond to emerging trends. It consists of a short questionnaire sent to approximately 10% of the registrant base each month at the top of the monthly newsletter.

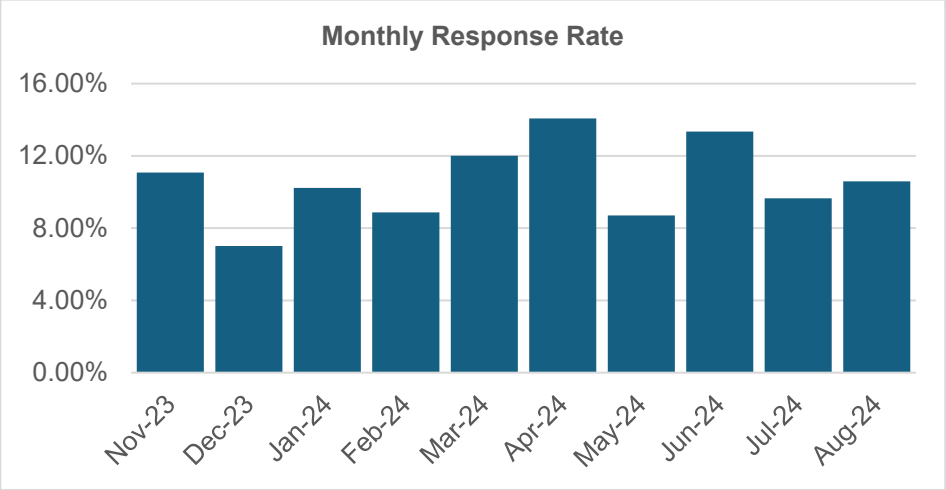
Preview the survey questions.

<table>
<tr><td>Output</td><td>

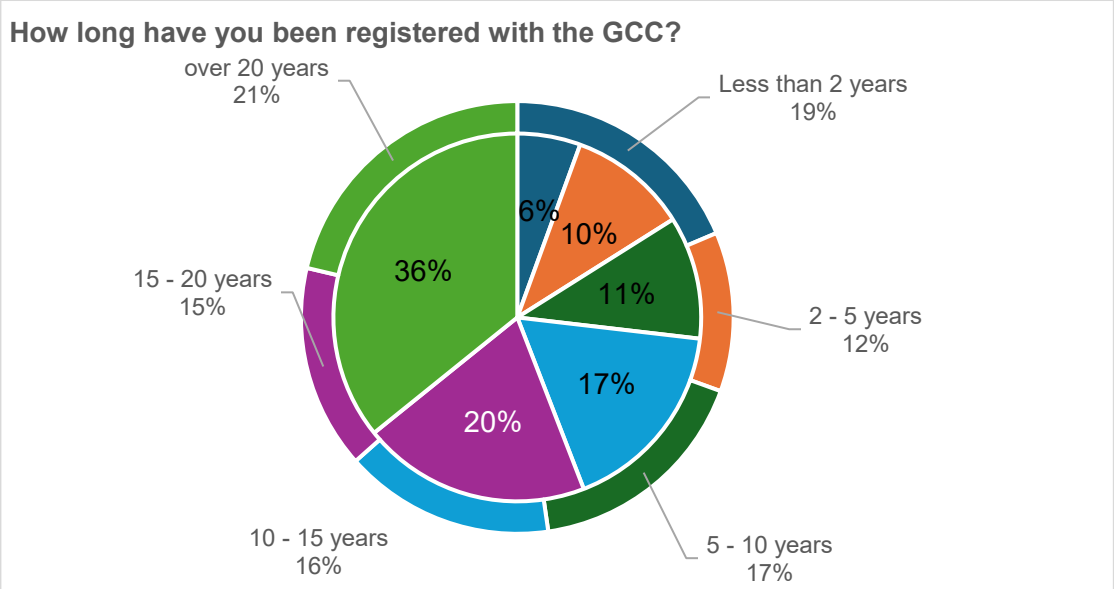
- Across the first year of the Pulse survey (from November 2023 to August 2024) 3836 individuals were invited to complete the Pulse survey,

</td></tr>
<tr><td>Engagement</td><td>

- Across the first year of the Survey we received 408 responses (10.61% response rate). This fluctuated between 7% (Dec 23) and 14% (Apr 2024).



- The Pulse Survey responses skew to the more established members of the profession (outer ring is the distribution within the whole register):



</td></tr>
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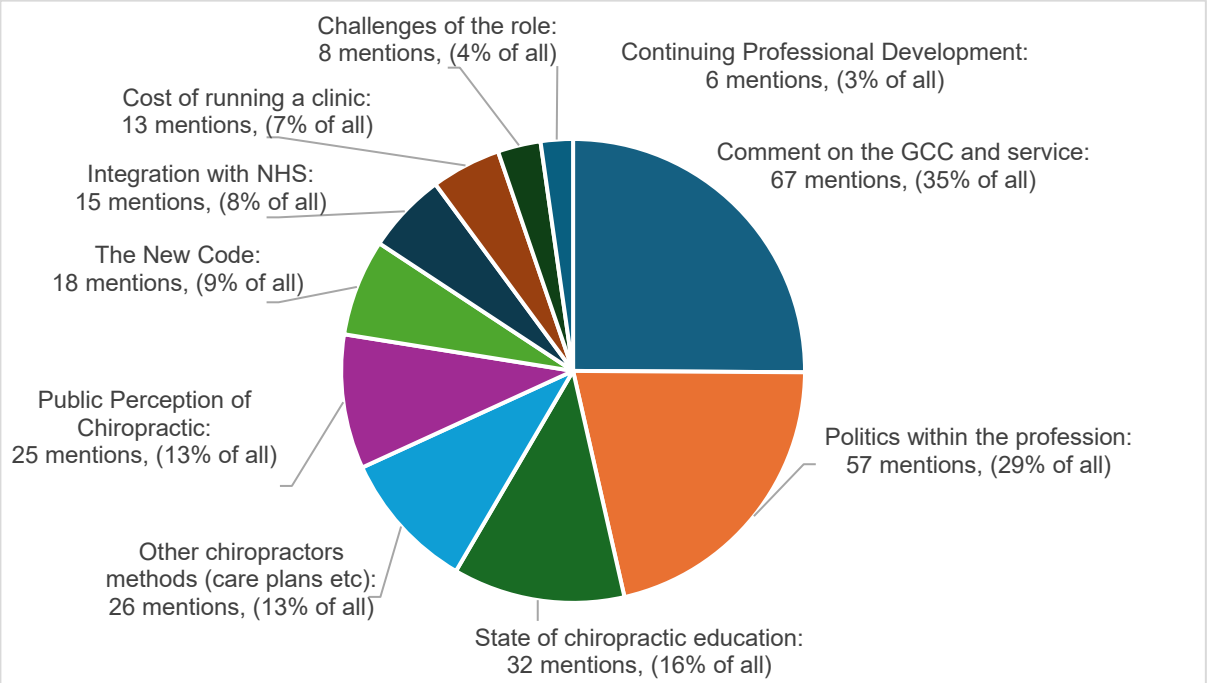
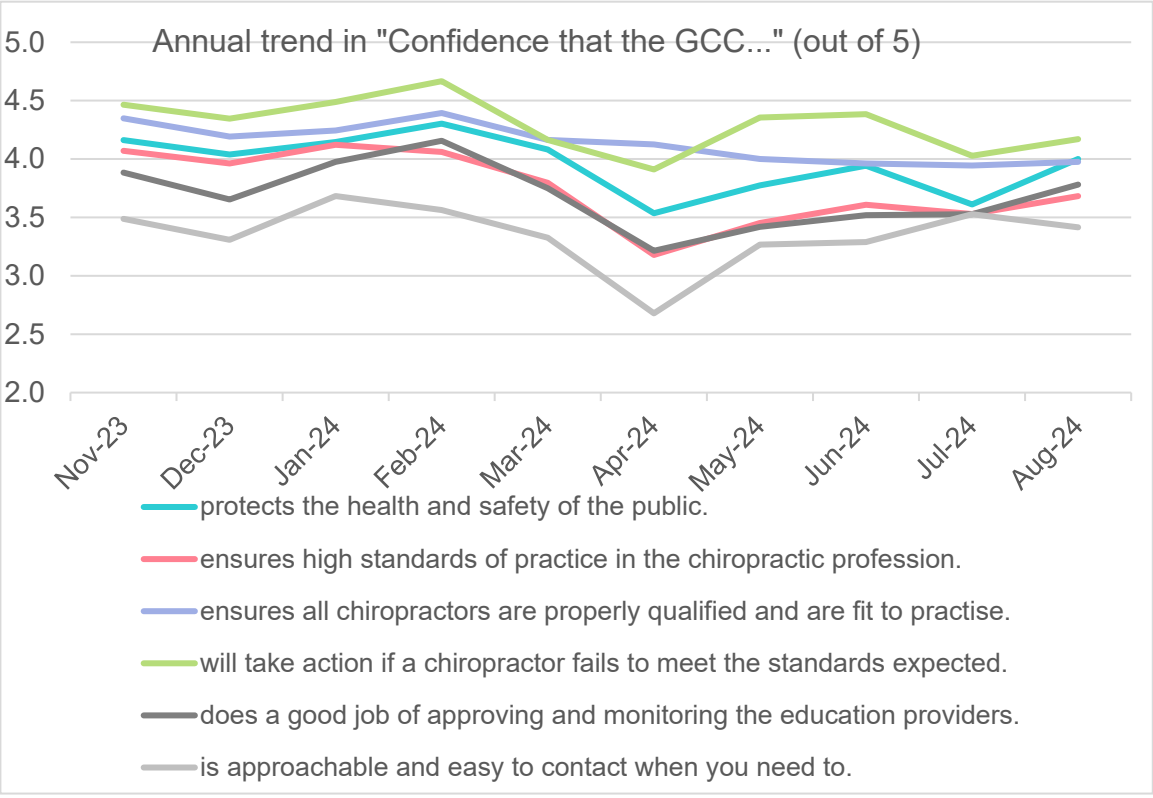
Target Action	• The comments section provided a valuable insight into the challenges and concerns of the registrants. Across the whole year there were 198 comments (some comments appear in multiple categories): 
Outcome	• The overall dashboard for The Pulse Survey can be seen on the next page. • Tracking the annual change in confidence in the GCC shows a decrease in confidence (and also an increase in responses) in April (coinciding with the Code Conversation). The exception is confidence that the GCC “ensures all chiropractors are properly qualified and fit to practise”. 

- There is a clear trend for chiropractors who have been registered between 5 and 10 years to be less positive about their job and less optimistic about the future of the profession.

Outcomes from comments

All comments are read, and a report is discussed at the monthly Performance Management Board each month. While many of the comments concern issues outside of the direct control or remit of the General Chiropractic Council, they are nevertheless valuable in helping GCC staff to understand the wider profession and are used to inform strategic and policy work such as the development of the Code of Professional Practice, and the development of the business plan.

Action taken in response to specific comments throughout the year include

Comparing the NHS website on physio and chiropractors was very eye opening. The websites uses very negative wording about chiropractic, whereas with physio is was very positive and said that it can help many things were as it did not with chiropractic.

- In response: The GCC successfully asked the NHS to adjust the wording on their website to highlight registration and the "I'm Registered" mark.

The profession is going from strength to strength. As I see it, the main issue holding us back is a lack of chiropractors. Hopefully, the new training schools will help with that, but it will take time.

- The GCC has overhauled the education pages of the website in order to explain the profession (and the GCC's role) better to prospective students. The GCC Linked-in account shared information about open-days on behalf of the education providers.

Costs for CPD and other courses should be capped. Some chiros want to do training but struggle to afford £400 upwards for one day.

- The GCC included an article in the May newsletter with suggestions for free and low-cost CPD.

Conclusions and learning

- Further development of the survey for 2024-2025.
- The last category in the confidence scale has been split into two parts – "is the GCC approachable" and "is the GCC easy to contact when you need to?"
- The "time on the register" question has been altered to ensure the categories are mutually exclusive (i.e. "5 years" no longer appears in two categories").
- A further question has been added asking if the respondent is a man or woman.

Next steps

We will report back to the profession on the findings of the first year of the Pulse Survey.

We will seek further evidence relating to ease of contacting the GCC.

We will consider in more depth the finding that positivity drops after 5 to 10 years in practice.

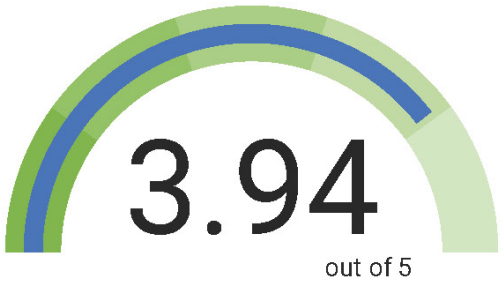
Pulse Survey

1 Oct 2023 - 31 Aug 2024

Invites	Responses	Comments
3,836	408	198
90.2% of register	10.61%	48.5%

Chiropractor Confidence in the GCC to...

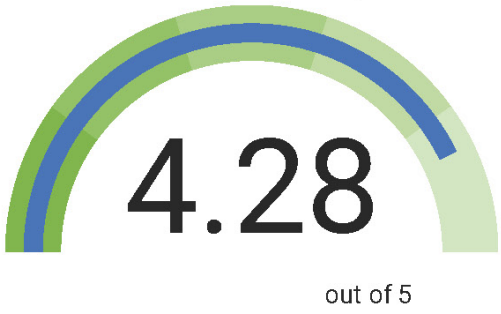
protect the health and safety of the public.



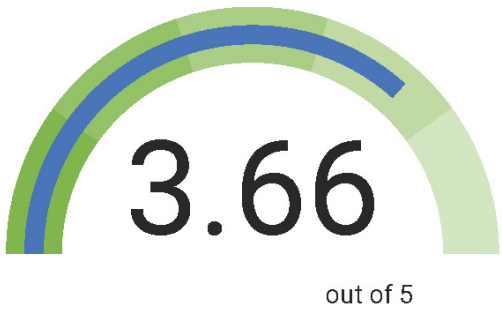
ensure high standards of practice in the chiropractic profession

ensure all chiropractors are properly qualified and are fit to practise

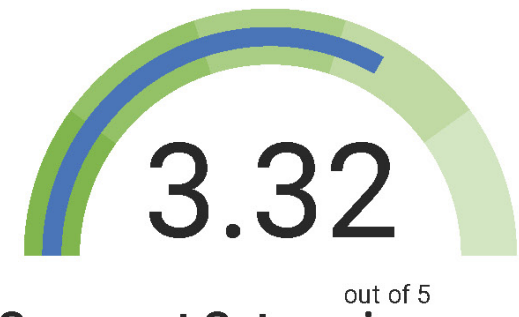
take action if a chiropractor fails to meet the standards expected



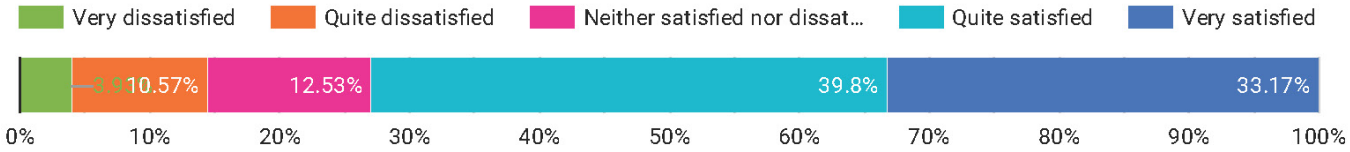
do a good job of approving and monitoring the UK chiropractic education providers



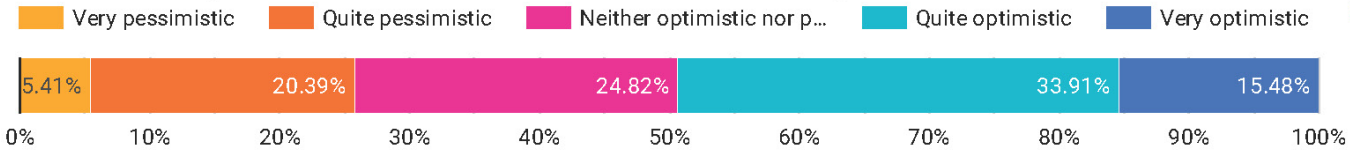
be approachable and easy to contact when you need to.



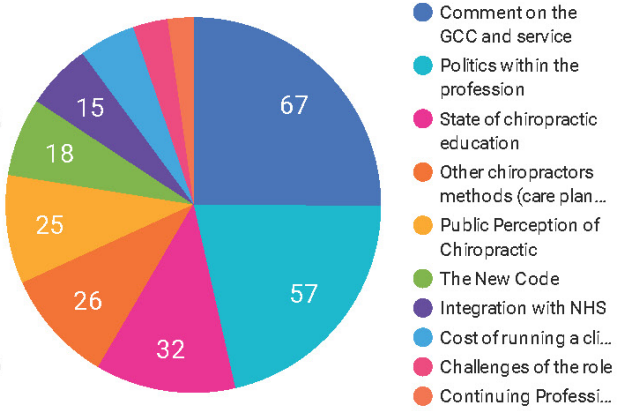
Satisfaction with the profession:



Optimism about the future of the profession:



Comment Categories



Equality, Diversity and Inclusion (EDI) Annual Report 2024

In 2022 the GCC adopted an ambitious 15-point three year action plan to help further its work and establish greater authority, responsibility and structure in future EDI activity.

As the final year of the action plan, 2024 has seen strong progress towards completing the plan by December 2024.

In September 2024 we were proud that our progress was acknowledged in the Professional Standards Authority (PSA) performance review, which highlighted many of our achievements concerning EDI:

Good practice

Extract from monitoring report 1 July 2023 to 30 June 2024

professional standards authority

We identified the following good practice under Outcome 2:

- The Education Standards for education providers have a clear focus on EDI. Providers must ensure students can apply and understand the principles of EDI and recognise the impact of discrimination and health inequalities.
- The GCC published best practice guidance for education providers on EDI to support education providers in meeting the Education Standards, and further information on EDI in its Student Clinical Placement Guidance.
- The EDI toolkit for registrants is designed to raise awareness of best practice and support chiropractors to meet legal requirements.
- The GCC made EDI the topic for the 'directed' element of CPD, publishing monthly EDI case studies in its newsletters to support registrants with their learning.

Activity towards the completion of the EDI action plan by December 2024

(Relevant action points are denoted in brackets).

- **The GCC EDI Working Group (1)** has continued to provide support and input into our plans, notably consulting on the internal and external surveys, the results of the Professional Conduct Committee thematic review, and the recruitment for EDI Champions.
- **Creation of EDI Champions (14).** These were initially going to be recruited from within the chiropractic profession, however the Working Group has determined that these should instead be from lay individuals with an interest in EDI, in order to share their lived experiences and provide critical feedback on EDI initiatives.
- **Defining EDI consultation (5).** This project sought to identify key concerns regarding EDI from GCC registrants and to develop an understanding of external stakeholders' opinions of the relevance of EDI within chiropractic. Following research in 2023, the reports were delivered for both the internal and external

surveys, and a comparison document was developed to look for common themes between the registrants and the wider public.

- **Mandatory EDI training (11)** has been put in place for all staff in 2024, which incorporates specific training for staff, managers, Council, committee and partners.
- The **EDI communication plan (9)** has been delivered throughout the year, with regular newsletter communications and EDI scenarios to encourage critical clinical thinking and reflective practice.
- An **EDI Best Practice Guidance (3)** document was developed for Education Providers which was delivered in January 2024. This includes best practice examples and recommendations, which can be used to support providers to meet the Education Standards. Available guidance and best practice from other healthcare regulators has been signposted.
- **An EDI Performance Tracker (15)** has been developed and is in use, this has been monitored and updated throughout the year to align our activities to the requirements set by the Professional Standards Authority.
- The **Continued Professional Development directed reflection activity** (12) for the CPD year 2023/24 was on EDI, and this was completed in August 2024. The reflections are now being analysed and a report will be produced for the Education Committee. To support registrants in their reflections, monthly real-life scenarios were prepared to assist registrants reflect on EDI and how it could affect their clinical practice.

Completion of the 15 point EDI action plan.

We now consider that all the objectives of the 15-point EDI action plan have been met with the exceptions of

- The **Operational Review for Protected Characteristics (10)** which is no longer required as, following consultation with the GCC's landlord (HCPC) the reception at the GCC offices has been determined to meet accessibility requirements.
- The recruitment of EDI Champions **(14)**. These roles have been scoped and will be recruited in 2025 to support the development of the EDI approach that will align with the new Corporate Strategy.

Additional Projects Achieved

- A webinar was held in January 2024 in conjunction with the Royal College of Chiropractors to highlight to new registrants the compulsory CPD requirements around EDI.
- Ongoing support has been provided by the Working Group Registrant Lead to the chiropractic associations and, in turn, their members as they completed the EDI focused CPD sessions and addressed issues encountered in clinical practice throughout the year.
- The Working Group Registrant Lead provided consultation and an "EDI lens" on the new Code of Professional Practice, helping to expand definitions, refine language and emphasise the requirements on registrants to address health inequalities.

- Recommendations for future EDI projects and a potential future action plan have been made following analysis and identification of industry trends.
- A thematic review considered PCC cases between 2020 and 2024 to identify if:
    - there are any fundamental issues of fairness within the PCC process
    - there are any links between EDI issues and complaints against registrants, either in the written commentary, the PCC committee members or in the registrant data on the GCC register of chiropractors.
    - there is a need to further support the GCC in steering actions, work or strategy that could tackle any identified issues that could impact disproportionality across fitness to practice referrals.

In addition to assessing potential fairness and justice issues within the PCC system, the analytics team sought to identify any links between protected characteristics, EDI concerns, and those referred to the PCC. The findings were shared with the Working Group, which welcomed the work and recognised the limits of the findings due to the small size of the sample.

Upcoming Projects

During 2025 we will seek to

- Develop an approach to EDI that will support the new Corporate Strategy.
- Review the aims and objectives of the EDI Working Group, along with work to recruit more members to the group, in particular students.

For approval

General Chiropractic Council

Strategic Risk Register at November 2024

Meeting paper for Council on 05 December 2024

Agenda Item: 08

Purpose

The effective management of our risks helps to strengthen the decision-making processes of Council, Committees and the Executive. It also helps to reduce both the possibility of a risk occurring and its potential impact. It additionally contributes to the protection of our reputation and in the achievement of a sustainable financial future for the GCC.

This report presents the six principal risks in the strategic risk register (SRR) which the Council last reviewed and approved in June 2024. The register is presented to Council at its meetings twice a year in June and December.

Recommendations

That the Council approves the Strategic Risk Register as of November 2024.

Summary

1. A summary of the six SRR is presented at **Annex 1**. The detailed register is at **Annex 2**.

2. Of the six risks in the SRR, four are currently rated as 'minor' (green) and two (future of the profession – i.e. DHSC reform and organisational capacity) are rated as 'moderate' (amber).

3. Through the Audit and Risk Committee (ARC) and Risk Management Group (RMG) meetings, we continued to strengthen the agreed risk controls to mitigate any potential risk failures and their impact on our operations since the last meeting.

4. In particular, we achieved the following risk mitigation response milestones in the register in the period under review:

- Achieved the set financial performance targets for the period to 31 October 2024.
- Drafted the 2025 Operating Budget for presentation to Council members at this meeting.
- Renewed the annual Cyber Essentials (CE) and Cyber Essentials Plus (CE+) certifications for the period to August and October 2025.
- Reviewed the timing of the conduct of the penetration test (pen-test) on our website and CRM (Registrant Portal) system from every three years to two. The next test will be conducted by Q2 2025; we also plan to conduct an additional test on the new Fitness to Practise (FtP) Case Management System (CMS), soon after the user-testing stage, in Q1 2025.
- Took the needed mitigation actions (i.e. ensured adequate resource deployment) to address the high staff turnover within the FtP team during the year; upgraded and de-escalated the risk rating for strategic risk number 4 (organisational capacity) during the year as follows:
  - upgraded the risk from moderate (amber) in Dec-23 to severe (red) in Jan-Apr-24
  - de-escalated risk from severe (red) to moderate (amber) between May-Jul-24
  - upgraded the risk once again from moderate (amber) to severe (red) between Aug-Oct-24); then,
  - downgraded the risk from severe (red) to the current moderate (amber) rating in Nov-24.

5. We currently assess our failure to identify significant emerging risks as minor (a green rating).

Background

GCC's risk agenda

6. Our risk agenda is designed to:
- Give assurance and confidence to Council and other stakeholders that we have robust risk management protocols in place and that we take our risk monitoring and reviewing seriously.
- Encourage and support clear decision-making at Council, Committee and Executive levels of the GCC. This includes the effectiveness of budget allocations, project planning and delivery.

GCC's risk appetite

7. This is the amount of risk that the Council is willing to take to achieve its strategic objectives. The Council noted the following **risk appetite ratings** for the six risks in the SRR at its meeting in June 2024. The ARC reviewed and noted same at its meetings in March, May and November 2024.

SR1	SR2	SR 3	SR 4	SR 5	SR 6
Failure to protect the public	Financial sustainability	Future of the profession	Organisational capacity	Cyber security	Governance
Low	Low	Medium	Medium	Low	Medium

8. From the above table, the Council and ARC have noted that three of the six strategic risks have "low" appetite ratings and the remaining three have "medium" scores.

Council and ARC responsibility

9. The Council is responsible for establishing policies and procedures for managing the risks to which the GCC is exposed. It also oversees the internal control framework and determines the principal risks the GCC is willing to take to achieve its long-term sustainable success.

10. The SRR is presented to Council at its meetings twice a year (i.e. in June and December).

11. The ARC has the delegated responsibility from Council to conduct regular risk assessments and review the GCC's risk management systems, including information on 'close calls'/'near-misses'.

12. The assessments are aimed at assisting the Council to determine whether the risk management systems in place are adequate to deal with known and emerging risks to the GCC.

13. The ARC reports its risk assessment findings to Council every March. These confirm whether the Committee members are satisfied with the GCC risk management policy and practices in place.

Risk Management Group (RMG) responsibility

14. The RMG acts as the **first and second** lines of assurance in the management of our strategic and operational risks. The **third, fourth and fifth** lines of assurance are the ARC, Council and independent external parties such as the external auditors and the Professional Standards Authority (PSA).

15. The Group is comprised of the senior management team and three co-opted risk champions drawn from front line staff, co-opted into the Group in Jun-22.

16. The Group meets monthly to review the SRR and operational risk register (ORR). The Group adopts a shared ownership approach to the management of the risks in both registers. The Group's meetings also provide the opportunity to ask insightful questions about potential '*black swan events'* and gaps in our current risk management approach.

Recommendations

That the Council approves the Strategic Risk Register as of November 2024.

Nick Jones

Chief Executive and Registrar

Annex 1 – Summary of the GCC SRR at November 2024

No	Risk event / category	Risk rating May-24	Risk rating Nov-24	Comment
1	**Failure to protect the public** GCC fails to meet core objective of public protection in FtP, Education and Registration. This may result in adverse publicity, critical reports by PSA, loss of confidence by stakeholders and ultimately reputational damage.	9	9	**Unchanged** since last meeting – with risk mitigation controls up-to-date.
2	**Financial sustainability/solvency** GCC fails to generate sufficient income from fees and investments to cover annual operating costs; with the external environment significantly affecting wage inflation, energy costs and general rises in operating costs.	6	6	**Unchanged** since last meeting – with risk mitigation controls up-to-date. For example, budget targets for the period to Oct-24 have been achieved. The 2024 Forecast Statement was approved by Council in Jun-24. The 2025 Operating Budget will be presented to Council for approval in Dec-24
3	**Future of the profession** The identity, voice and legitimacy of the profession, alongside the potential for regulatory reform and changes to regulation, lead to a fracturing of the profession and increased risks faced by patients.	16	16	**Unchanged** since last meeting. Council approved, by correspondence, the downgrade of this risk from red (severe) to amber (moderate) in Aug-23.
4	**Organisational capacity** GCC is unable to meet core functions due to a lack of capacity – principally, sufficiency of staff with the competence and skills to deliver the business plan.	16	16	• Due to high staff turnover within the FtP team, reviewed this risk rating from moderate (amber) in Dec-23 to severe (red) in Jan-Apr-24. Then, de-escalated it to moderate (amber) between May-Jul-24. Upgraded the risk once again from moderate (amber) to severe (red) between Aug-Oct-24). • Following adequate mitigation response to the staffing issues in the FtP team, this risk was assessed to be moderate (amber) in Nov-24.
5	**Cyber security** The GCC is subject to a denial of service due to cyber-attack disrupting operational capability for a lengthy period and/or loss of data. This results in our inability to meet core statutory objectives which causes significant reputational damage.	9	9	**Unchanged** since last meeting – with risk mitigation controls up-to-date. For example: • We will conduct a pen-test on our IT standard infrastructure every 2 years – plus test all newly implemented IT systems. The next pen-test is scheduled to be done by Q2 2025. The last test was in Jun-23. • We plan to test the newly implemented FtP CMS by Jan-25. • Our policy on, and approach to, cyber security was reviewed and noted by the ARC and RMG in Nov-23 and Jan-24. • Our basic Cyber Essentials (CE) and Cyber Essentials Plus (CE+) certifications are valid until August and October 2025.

6	**Governance** GCC does not have sufficient arrangements for effective governance to ensure the delivery of strategic and operational objectives.	9	9	**Unchanged** since last meeting – with risk mitigation controls up-to-date.

GCC - STRATEGIC RISK REGISTER (SRR) NOVEMBER 2024

ID	Risk Event	Date Identified / Re-categorised	Risk Category	Risk Owner	Controls in Operation	Gaps in Controls	Mitigation Response	Response Completion Date	Residual Score			Council and/or Committee Assurance	Further Actions (i.e. progress to-date on the achievement of the agreed mitigation response targets/milestones [Column M])	Risk Appetite
									Value: Last Period	Trend	Value: This Period			
									S=Lxl+I		S=Lxl+I			
SR1	**Failure to protect the public** GCC fails to meet core objective of public protection in FtP, Education and Registration. This may result in adverse publicity, critical reports by PSA, loss of confidence by stakeholders and ultimately reputational damage.	Mar-22	**Reputational risk**	D, DEV D, FTP	Regular reporting of performance through monthly executive and quarterly Council scrutiny. Formal contractual relationship with legal advisers – handling all PCC matters and general advice available Close scrutiny of the performance by Education Committee on education programme and registration activities, including CPD. Committee draws on advice of appointed external experts.	Partial business continuity arrangements in some key functions, notably data management and registration.	Enhanced implemented CRM system digitising core tasks; training of wider group of staff on system.	Completed in 2020 followed by staff training in Nov-22; ongoing review since.	9	=	9	COUNCIL / ARC	1) **GCC's performance review for 2023/24** We did not meet all 18 standards set by the PSA for regulators - Failed standard 15: The regulator's process for examining and investigating cases is fair, proportionate, deals with cases as quickly as is consistent with a fair resolution of the case and ensures that appropriate evidence is available to support decision-makers to reach a fair decision that protects the public at each stage of the process. 2) **New Education Standards** effective from 1 March 2023. All programmes aligned with the ES from September 2024. 3) **Code Review** - Consultation concluded and all responses analysed. Final Code of Professional Practice and associated documents to be presented to Council in December 2024.	Low
SR2	**Financial sustainability/solvency** GCC fails to generate sufficient income from fees and investments to cover annual operating costs; with the external environment significantly affecting wage inflation, energy costs and general rises in operating costs.	Mar-22	**Financial / Liquidity**	DCS	Produce a new 3-year financial strategy for 2023-25 for Council approval. Produce budget and forecast income statements for Council approval. Produce management accounts for the Executive/Audit and Risk Committee, ARC/GCC Chair and Council, and take corrective actions as they arise. Reserves policy Financial emergency Protection of GCC funds invested/deposited with financial institutions - regular reviews.	Stress-test the key variables in the 3-year financial plan and alert Council to potential risks and mitigation strategies. Stress-test the key variables in the budget and forecast statements and alert Council to potential risks and mitigation strategies.	To ensure financial sustainability, achieve a minimum of 1.5% surplus margin each year. Prepare a 'balanced' budget for the next financial year effective 1 January, and have Council's sign-off by December of the prior year. 1) Circulate monthly management accounts report to Budget Holders for review and action. 2) Circulate quarterly management accounts to ARC and Council for review and action. Achieve the reserves policy of holding six months annual operating costs. In a financial emergency, Council to decide how much of the investment portfolio and general reserve is to be drawndown each year. A business case is to be made by the Executive. Keep an eye on the retail banking sector for any contagion effect of potential bank failures (i.e. SVB and then Credit Suisse recently) in the USA and Switzerland on the sector's activities.	Completed June 2022; ongoing review since 1) Draft Budget: December Council meeting 2) Forecast Income Statement: June Council meeting 1) Budget Holders: Within 5 working days of the end of calendar month 2) ARC and Council: Within 5 working days of end of quarter February each year When required Ongoing monitoring of the emerging potential banking crisis - and to respond swiftly to protect GCC funds	6	=	6	COUNCIL / ARC	**Financial Strategy 2023-25** The 3-year financial strategy 2023-25, including the 7 recommendations therein, was approved by Council in Jun-22. **Budget and Forecast Income Statements 2024** 1) The 2024 Draft Budget was approved by Council in Dec-23 with an expected budget surplus of £72k (2% surplus margin). The target surplus margin in the Financial Strategy 2023-25 is 1.5%. 2) The Forecast 2024 income statement was approved by Council in Jun-24. A deficit (caused by unexpected staffing issues within the FTP team) is currently expected to be realised for the year. **Use of Designated Reserves** 1) **Mar-24:** As previously agreed in-principle by Council, proposals for the drawdown of the designated reserves are to be made to Council when required. Last reviewed by the Audit & Risk Committee (ARC) on 06/Mar/24. Committee agreed to recommend to Council that the current free reserve and designated reserve policies should be maintained going forward. 2) **Sep-24:** Council reviewed an options paper on reserves available for use and increasing the current investment returns targets. Agreed to maintain the general reserve at six months' cover. **Budget and Forecast Income Statements 2025** Dec-24: Council to review and approve Budget-25.	Low
SR3	**Future of the profession** The identity, voice and legitimacy of the profession, alongside the potential for regulatory reform and changes to regulation, lead to a fracturing of the profession and increased risks faced by patients.	Mar-22	**Business risk**	CER	Regular and sustained involvement in reform developments notably the S.60 Order and review of regulators, including meeting with Director General. Surveillance of the professional and regulatory landscape – monitoring of social media; regular meetings with stakeholders (as SR1) and CERs group. Routine reporting of developments to Council.	The Executive capacity is limited. As soon as we get additional requirements as a result of reform (i.e. s60 becomes real), we will need to act swiftly to provide the needed additional capacity.	*If the regulatory reform proposals by the DHSC are judged to be fully implementable:* 1) Develop a communication and engagement plan with stakeholders (i.e. registrants, professional bodies and GCC staff). 2) Present a business case to Council to release some funds from reserves to meet capacity needs - when required.		16	=	16	COUNCIL	**Draft Order** **Feb-23 - DHSC issued draft Order** and response to April 2021 consultation. Our initial priorities was to absorb and understand proposals; socialised with Council (14 March 23). Closely monitor the implementation of the reform proposals and develop a communication and engagement plan with stakeholders (i.e. Registrants, professional bodies and staff) in due course. Currently premature to develop rules; output here is response to consultation by May 2023. **Apr-23 - response to consultation** Commissioned a legal firm (Fieldfisher) to support our response to the consultation. Response to the consultation completed and presented to Council. Response included outcomes of the meeting with professional stakeholders views of patients and registrants. **Aug-23 - risk downgrade** a) Following a concern raised by Council in Jun-23 about the rating of this risk, the GCC Risk Management Group (RMG) reviewed the risk and recommended its downgrade from red (severe) to amber (moderate) in Jul-23. b) Council discussed and approved (by correspondence) the downgrade of this risk from red to amber in Aug-23. **Oct-23 - publication of timetable** The DHSC is yet to publish a clear timetable for its next phases of work. However, the DHSC say that their initial timeline is achievable. If met, likely that we will be developing rules in 2024. Significant cost implications - review of business/operating plans and financial implications in the short-term. **Mar-24 - GMC Order published** No news on application to the GCC or other regulators. Continuing to monitor.	Medium

	ID	Risk Event	Date Identified / Re-categorised	Risk Category	Risk Owner	Controls in Operation	Gaps in Controls	Mitigation Response	Response Completion Date	Residual Score			Council and/or Committee Assurance	Further Actions (i.e. progress to-date on the achievement of the agreed mitigation response targets/milestones [Column M])	Risk Appetite
										Value: Last Period	Trend	Value: This Period			
23	SR4	**Organisational capacity** GCC is unable to meet core functions due to a lack of capacity – principally, sufficiency of staff with the competence and skills to deliver the business plan and wider governance matters of the GCC.	Mar-22	**Operational risk**	CER	Executive arrangements for performance scrutiny - monthly Performance Management Board (PMB) meetings to act as early warning.	Resource constraints (financial and staffing)	Development of procedure guides on data systems – that is FtP and CRM data systems.	Daily	16	=	16	COUNCIL	a) Procedure guides completed in 2020 with ongoing review. b) There is the risk of not implementing CMS by Dec-24 due to staffing issues with the FTP team.	Medium
24						Suite of employment policies including probation, performance appraisal and objective-setting and consistent application by Directors for their teams.		Review the existing divisional cover arrangements in place.	Completed Jun-21 with regular review by the team					Completed in 2020 with ongoing review.	
25						GCC operating model intended to ensure optimal working patterns in place.			Completed 01/11/2022 with regular review by the team					**Corporate Services** team re-visited its cover arrangements in Jun-22. Ongoing development of process maps for its core finance and payroll activities. Extra resilience deployed in the **Development** team. **Fitness to Practise (FtP)** process documents are up-to-date.	
26						Business continuity plans and ability to use temporary staff to cover for prolonged staff absences.		Allowed for a contingency amount for temporary staff cover in the 2024 Budget.	Completed 01/12/2022 with ongoing review by the team					a) Increased the risk rating of strategic risk number 4 (organisational capacity) from moderate (amber) to severe (red) from January- April 2024; b) Reduced the rating to moderate (amber) between May - July 2024 following the robust mitigation response to the high staff turnover within the Fitness to Practise (FtP) team, alongside the recruitment exercises for the vacant roles in the team. c) Increased the rating from Amber to severe (red) in August - October 2024 due to staff shortages. d) Downgraded the rating from severe (red) to moderate (amber) from November 2024 in response to completion of all mitigation measures.	
27															
28															
29	SR5	**Cyber security** The GCC is subject to a denial of service due to cyber attack disrupting operational capability for a lengthy period and/or loss of data. This results in our inability to meet core statutory objectives which causes significant reputational damage.	Mar-22	**Operational risk**	DCS	IT support and data storage systems are outsourced.	Lack of control over business continuity arrangements of IT support company.	To manage third party IT supplier risks, agree a business continuity plan with current IT support company to cover continuity of service and data back-ups (for cloud-based and offline systems).	Completed policy with current IT support company in Oct-21; updated the policy in 2024	9	=	9	EXECUTIVE / ARC / COUNCIL		Low
30						Data storage is in the cloud.		Daily backups by IT support company.	Completed 01/10/2020 with annual reviews						
31						No information is stored on employee's devices. Access to GCC systems subject to multi-stage authentication.									
32						Obtain recognised cyber certifications annually and display on GCC website.		Obtain Cyber essentials (CE) and CE+) certifications each year and display on GCC website. CE is the self-certified standard version. Cyber Essentials Plus is awarded following an on-site visit by an assessor (such as Cyber Strategies). CE Plus standard is optional but often required when working with Government agencies and platforms.	Reviewed in August and October of each year; last certifications: Aug-24 and Oct-24)					1) CE certification for 2024-25 completed in Aug-24 **(valid until Aug-25)**. 2) CE+ certification 2024-25 was completed in Oct-24 (assessment took place in Sep-24 but certificate issued later). This is **valid until Oct-25**.	
33						Disaster recovery plan agreed with IT support company. Annual data simulation test is not required, given that data is saved/backed-up in the cloud (effective Oct-23).		Agreed data recovery time with IT support company ranges from 4 to 6 hours (and up to 2 days for complete system failure).	1) Application packages: up to 4 hours. 2. Data on SharePoint: up to 6 hours. 3. Emails: up to 1 day. 4. Complete Office 365 Failure: up to 2 days.					1) A paper on GCC's approach to cyber security and cyber threats mitigation strategies was received and noted by the Audit and Risk Committee in Nov-23. 2) The mitigation strategies include CE and CE+ certifications; cyber attack simulation tests and penetration tests. The strategies are to be actioned in conjunction with the GCC Disaster Recovery Plan. 3) With the IT system upgrade to SharePoint, the annual data recovery test is no longer required. An updated Disaster Recovery Plan has been developed with our current IT support company.	
34						Penetration testing of GCC IT infrastructure is carried out at pre-determined intervals - with assessed low risk of 'rogue actors' penetrating our IT architecture.		1) Conduct penetration tests on the GCC's IT infrastructure. 2) Penetration test is to be conducted every two year years **and** whenever a new IT system (i.e. FtP CMS) is added to the GCC IT infrastructure.	Last test: Jun-23; next test: Jun-25 **31/03/24:** Testing frequency to be benchmarked against 'best practice' guidelines (i.e. CE and NCSC).					**1) Pen-test findings highlight vulnerabilities** to be fixed by GCC software developers (i.e. iMIS and Optima). Confirmed on 08/03/24 that all the vulnerabilities had been fixed; and with assurances from the software developers that vulnerabilities requiring development work would be done in 2024. **2) Apr-24 RMG Meeting:** Looked into best practice pen-testing cycles. Both CE and NCSC do not have guidance on minimum pen-testing period. Regularity of the tests will depend factors such as size of organisation, testing costs, risk appetite and how often new IT systems are added to the organisation's IT infrastructure. **3) Recommended Action:** Conduct the Pen-test every 2 years - **plus** test soon after a new IT system is added to the GCC IT infrastructure (i.e. CMS).	
35						Staff training on cyber security.		Organise cyber security training for staff (10 modules to be completed).	Completed 01/11/23 and 31/01/24; next training modules will be in 2025					All staff last completed the cyber security training course between 01/11/23 and on 31/01/24.	
36						GCC to work with other regulator-organisations to collaborate on conducting internal audit on non-financial areas of work (i.e. cyber attack, BCP, procurement, HR, etc).		Focus on one area of benchmarking exercise/internal audit with comparable regulator-organisation - at least once every three years.	Last "IA" was in 2021 was on our risk management framework and practices. Next exercise TBC.					Review of the GCC business risk policy (i.e. insuring GCC assets, cyber, public liability, other business risks) for 2024 calendar year was completed in Nov-23.	

ID	Risk Event	Date Identified / Re-categorised	Risk Category	Risk Owner	Controls in Operation	Gaps in Controls	Mitigation Response	Response Completion Date	Residual Score: Value: Last Period	Residual Score: Trend	Residual Score: Value: This Period	Council and/or Committee Assurance	Further Actions (i.e. progress to-date on the achievement of the agreed mitigation response targets/milestones [Column M])	Risk Appetite
					Review risk financing mechanisms to ensure retained risks can be funded from unrestricted reserves each financial year.		Review annual business risk policy with insurers.	Reviewed annually; last reviewed in Nov-24					**ARC Annual Risk Assessment Statement to Council:** 1) On the recommendation of the members of the Committee, Council agreed on 20/03/24 that they were satisfied the GCC's risk management strategy and practices were effectively being managed; they were strengthened throughout 2023 calendar year; and were achieving the desired risk mitigation results. 2) Next ARC Annual Risk Assessment Statement to Council: Mar-25	
					GCC will not pay 'rogue actors' in the event of a ransomware attack.		Activate agreed actions when risk arises.							
SR6	**Governance** GCC does not have sufficient arrangements for effective governance to ensure the delivery of strategic and operational objectives.	Mar-22	**Governance risk**	CER	Annual effectiveness reviews of Council and Committees undertaken.	1) Formalise the process of communicating findings from annual appraisals (to inform budget-setting so CPD costs are allowed for in the budget). 2. Non-alignment of dates for conducting and reporting Committee and Council effectiveness surveys. 3. Gaps in the recruitment of Committee and Council members.	**Conduct of annual effectiveness surveys** 1) **EC** to conduct its effectiveness survey every 2 years (next survey due: TBA, given new Chair in post). 2) **ARC / RemHR:** conduct committee effectiveness survey - every 2 years. Take necessary corrective actions. 3) **IC and PCC:** no effectiveness surveys as the Committees present their annual reports to Council each March. **Reporting of effectiveness survey results to Council** 1) **EC and RemHR:** report the survey findings to Council. 2) **ARC:** report the survey findings to Council. **Succession Planning** Provide sufficient resources in the annual budget for Council, Committees and Partner recruitment.	**Conduct of next effectiveness surveys** 1) **EC:** Mid-2024 2) **ARC/RemHR Committees:** Nov-24 to Jan-25 **Reporting of survey results** 1) **EC:** Sep-24 2) **ARC/RemHR:** Jun-25	9	=	9	EXECUTIVE / ARC / COUNCIL	a) The Council effectiveness review was completed in Jun-22. Actions were agreed in Sep-22. b) A proposal for the next review was considered by Council in Sep-24. The next Council effectiveness review is planned to be conducted in 2025.	Medium
					Succession planning arrangements in place for Council, Committees and Partners.		**Conduct annual appraisals of Council and Committee** members between November and January of each year. Report on actionable findings to Council in June.	**Jan-23:** Concluded appraisals and reported to Council in Jun-24					Completed.	
					Governance policies and procedures in place.		**Undertake review of Council performance by external consultant** at least once every three years (or as the Chair of Council sees fit).	1) **Last review:** 2022 2) **Next Review:** Jun-2025 (TBA by Chair of Council)					The recruitment of new Chair of Council went to plan.	
					Clear strategy and business planning cycle (from SRR1). Regular reporting of performance through monthly executive and quarterly Council scrutiny.		**Develop Corporate Strategy for 2025 onwards.**	1) **First Draft** for Sep-24 Council meeting; 2) Second Draft for Dec-24 Council meeting; 3) **Final Draft** for March 2025 Council meeting; and 4) **Support Strategies** (including Financial Strategy 2025-2030) for Council Jun-					1) Executive and Council discussed the review and development of the GCC Strategy for 2025 onwards in Jun-24. An outline was presented to Council at its Sept-24 meeting for their comments. 2) Second draft 2025-2030 Strategy to be presented to Council in Dec-24. 4) Support strategies (to support Strategy 2025-2030) to be presented to Council, Jun-25.	
					Additional meetings with Council possible to maintain contact and focus on strategy								Professional Associations have enquired about Council's decision to re-appoint members of Council rather than go through an open competition. This affected four (4) Council members whose term of office ended in 2024. Hitherto, no issue. CER spoke to Chair of Council about it. Re-appointments were concluded in May-24.	

KEY

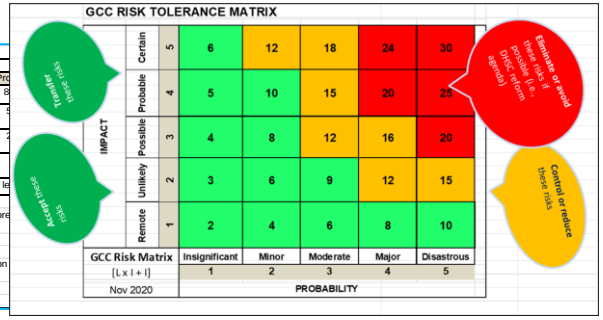
Inherent risk:	Gross risk exposure before we put mitigation controls in place
Residual risk:	Net risk exposure after we put mitigation controls in place
Risk appetite:	This is the amount of risk GCC Council is willing to take in order to achieve its strategic objectives.
Risk tolerance:	This is the amount of risk the GCC is prepared to accept in order to achieve its financial objectives. We can best understand risk tolerance when linked to our RAG reporting: intolerable, if the risk score is in the red zone; tolerable, if in the amber zone; green zone shows preferred limit of tolerance.
Risk attitude:	Our response to a single decision (i.e. GCC's investment decision and how much risk to take) which could result in a potential positive or negative outcome (i.e. portfolio growth or decline).
Business/disruptive risk:	Risk arising from changes in current and potential registrants' interests in the Chiropractic profession, changes in UK economic and political conditions.
Financial/liquidity risk:	Risk that the GCC is unable to fund its short and long-term liabilities due to insufficient funds.
Operational risk:	Risk arising from inadequate internal processes and systems leading to loss events.
Reputational risk:	Risk from loss of damages to GCC's reputation, its brand name and perceived goodwill.

Risk classification guidance

Level	Impact	Likelihood	Pro
5	The organisation would not survive.	Certain	8
4	Major impact on the achievement of the organisation's business plan and the quality of its overall services.	Probable (likely to happen each year)	5
3	Significant impact on the success of the business and quality of its services.	Possible (could happen in the next three years)	2
2	Some impact on the organisation's staff and minor effect on its clients.	Unlikely (may happen in the next five years)	
1	Insignificant impact on the organisation or its staff.	Remote	Id

The **impact score** is usually multiplied by the score for likelihood and the product of the scores added to the impact score the total score to determine which risks are tolerable, intolerable or within our preferred limit of risk tolerance.

Inherent & Residual Risk
Risk should be re-assessed in light of counter-measures to assess whether either have been reduced as result of action either have been reduced then the assessment of residual risk should be recorded.



General Chiropractic Council

For approval

Review of the Code of Professional Practice

Meeting paper for Council on 5 December 2024

Agenda Item: 09

Purpose

The purpose of this paper is for Council to review and approve the post consultation Code of Professional Practice.

Recommendations

Council is asked to:

- note the report from Community Research
- note the consultation response document
- approve the new Code of Professional Practice
- approve the equality impact assessment and Welsh language impact assessment
- delegate approval of the Glossary to the Chair.

Background

1) In January 2024 we launched a full review of the Code, following the scoping review of 2023. The purpose of the review was to revise and update the Code, which came into effect on 30 June 2016. The Code encompasses both Standards of Proficiency and Standards of Conduct and Practice.

2) Determining the Code is a key statutory responsibility for the GCC. The Council recognises that most chiropractors uphold high professional standards, but that on occasion, a small proportion fall short. The Code of Professional Practice is intended to provide a framework to support registrants provide safe, high quality care in the best interests of patients and give patients and public assurance of this.

3) Following the June Council meeting at which Council approved the consultation documents and the title: the 'Code of Professional Practice', we undertook a full public consultation on our proposed changes, which was open from 22 July until 27 September 2024. It was promoted to registrants, the profession and patients through various direct and indirect communications. We made the consultation available in English and Welsh.

4) During the consultation phase we held a series of events. Three consultation events for registrants were convened in partnership with the Professional Associations and seven discussion sessions were convened with specific audiences including Professional Associations, Educationalists, the Royal College of Chiropractors and those involved in Fitness to Practise proceedings.

5) By its close, the consultation prompted 116 online survey responses from a range of stakeholders including registrants and patients/members of the public and 6 responses from Professional Associations, Regulators and other organisations.

6) The GCC commissioned an independent research company, Community Research, to summarise the main feedback received. This report can be found at **Annex A** and is structured to provide a thematic overview of the feedback. Members should note that the report refers to the Standards as numbered in the consultation. Following a review of the consultation feedback some Standards in the final Code of Professional Practice have been re-numbered or removed.

7) The key themes emerging from the independent Community Research report were used to identify specific areas of focus for improvement and development within the final Code of Professional Conduct.

8) In early November we presented a summary of the feedback received during the Consultation to Council members and discussed some key themes:

- The role and purpose of the Code of Professional Practice in setting a reasonable standard for the patient to expect of a chiropractor, as opposed to a minimum standard or an aspirational or “gold” standard.
- The appropriateness of the terms “must” and “should” to signal within the Code of Professional Practice where a Standard was included to encourage behaviour rather than to enforce it. Specific focus was given to B5 and the enforceability (and appropriateness) of mandating use of safety systems. This discussion highlighted the difference between knowledge-based Standards and action-based Standards, and the appropriateness of redefining some Standards in terms of knowledge.
- The definition of evidence within the proposed Code of Professional Practice. Council agreed that “evidence-informed” was not a more appropriate term than “evidence-based” and highlighted the need for clarity and consistency of approach throughout the document.
- Council members were also specifically asked to consider whether they agreed with the proposed approach to the ASA and other regulators (C4), and to consider whether the Code of Professional Practice adequately dealt with concerns relating to the use of Artificial Intelligence (AI) in chiropractic practice.

Analysis

9) The drafting of a revised Code of Professional Practice was largely welcomed, in light of changing societal trends, technology and patient expectations since the previous iteration. There were perceived to be few gaps in the content and the expansion of specific areas, namely safety and equality, diversity and inclusion, were, by some, felt to be very positive. The other Healthcare Regulators who responded to the consultation were largely positive about the changes to the draft Code of Professional Practice, commenting that they are in tune with current developments in the sector and their own revised guidance. They particularly praised the focus on a patient-centred approach.

10) When taken all together, responses from the consultation on the new draft Code of Professional Practice were overall positive, constructive and well received.

11) We have carefully reviewed all the feedback that we received during the consultation. In total 1345 comments were categorised, reviewed and considered across the Standards and Principles of the Code of Professional Practice.

12) The majority of feedback concerned the drafting of the Standards, as opposed to the drafting of each Principle. Each Principle now begins with “You must”. Principle F has been changed to reference “valid” rather than “informed” consent, to provide consistency. We have made some minor changes to Principle introductions to improve clarity, brevity and /or to set clear expectations. Each set of Standards is now prefaced by ‘As a chiropractor you must:’.

13) Each Standard was considered carefully alongside: the equivalent Standard in the 2016 Code; the Standards of Proficiency (as agreed by the Education Committee); the Education Standards; the thematic review; and the consultation comments relevant to that specific Standard.

14) Section 9 of the Response to Consultation document identifies the changes made to each Standard. In total 14 Standards remained unchanged, 30 were reworded (for clarity or consistency) without changing their meaning.

15) In 33 cases the update to the Standard was judged to change the meaning, scope or approach within the Standard (in most cases this was a very minor change). Where this is the case, the change is described in the Response to Consultation document. Four Standards were removed or combined due to duplication or overlap with the remit of another regulator.

16) We would draw the attention of Council to the following Standards where, in our opinion, the greatest change has been made:

    i) **Standard A4** which has been adjusted to balance the rights of the patient over who is in the room with them during treatment with the rights of the chiropractor to require a chaperone (**Standard E4**).
    ii) **Standard B4** where the chiropractor must understand the role of a suitable safety system, but is no longer mandated to use it.
    iii) **Standard C4** where the term “do not unreasonably deny care” has been removed.
    iv) **Standard D6, D7 and D8** which have been reworded to clarify the stages of proposing a plan of care.
    v) **Standard E1** has been widened to highlight all power imbalances – not only those between a patient and practitioner.
    vi) **Principle J** where a number of standards that overlapped with data protection legislation have been removed.

17) We sought legal advice to ensure the final Code of Professional Practice is legally sound, from both public law and enforceability perspectives.

18) The final Code of Professional Practice can be found at **Annex C.**

19) The glossary plays an important role in defining the use of the specific terms within the Code of Professional Practice. While the list of terms to be defined in the glossary is complete, the definitions themselves still require some consideration (as they need to be tested in the context of each use). For this reason we respectfully request that the Chair of Council be given the responsibility to sign off the glossary once this final piece of work is complete.

20) We recognise that stakeholders would value additional guidance to support implementation of some of the Standards, particularly where we have set new expectations. We have already committed to revising and updating the current guidance on Maintaining Sexual Boundaries during 2025, informed by our recent research with patients. Further new guidance will be determined during 2025 and may be subject to consultation.

21) The Equality Impact Assessment (EQI), which was published alongside the consultation, has been updated post consultation and can be found at **Annex D.**

Implementation

22) Section 13 of the Chiropractors Act 1994 requires that the GCC publish a revised Standard of Proficiency, accompanied by a statement of the differences between that Standard and the Standard as it was immediately before the revision. The variation of the Standard shall not have effect until the end of the period of one year following the date on which the Council publishes those documents.

23) As such, the Code of Professional Practice, and the statement outlining the changes in relation to the 2016 Code will be published on or before 31 December 2024. The Code of Professional Practice will come into effect from 1 January 2026.

24) The Code of Professional Practice will be published in English and Welsh.

25) We recognise the importance of supporting the implementation of the new Code of Professional Practice through a range of communication activities. The 2025 Business Plan focuses both on presenting the Code of Professional Practice to the profession as well as patients and on updating of existing guidance, policies and processes to ensure consistency with the new standards and producing new guidance where required. We will begin that programme of work once we have published the new Code of Professional Practice.

Penny Bance
Director of Development

GCC Code consultation

Feedback report

November 2024

community research

Bringing the voices of communities into the heart of organisations

Contents

1. Executive summary

1.1 Introduction

The GCC Code encompasses both Standards of Proficiency and Standards of Conduct and Practice for chiropractors. Following engagement with the sector, the GCC has now drafted a new version of the Code and launched a formal consultation on the content which ended on the 27th September 2024.

In total, 121 responses were received in response to the online survey; the majority of which were registered chiropractors. The online survey was supplemented by a series of events, including events convened in partnership with the Professional Associations and discussion sessions with specific audiences, including Professional Associations, Educationalists, the Royal College of Chiropractors and those involved in Fitness to Practise proceedings.

1.2 Summary of feedback

The drafting of a revised Code was largely welcomed, in light of changing societal trends, technology and patient expectations since the previous iteration. There were perceived to be few gaps in the content and the expansion of specific areas, namely safety and equality, diversity and inclusion were, by some, felt to be very positive. The other Healthcare Regulators who responded to the consultation were largely positive about the changes to the draft Code, commenting that they are in tune with current developments in the sector and their own revised guidance. They particularly praised the focus on a patient-centred approach.

For each Principle, survey respondents were asked *'to what extent do you agree or disagree that the Standards describe the minimum expectations that must be met by registrants in relation to this Principle?*. Overall there were high levels of agreement with this statement for all Principles. Lowest levels of agreement were for Principles D and H (with 78% and 80% agreeing respectively).

The draft Code was felt to be more aspirational in tone than earlier versions. This resonated with some, particularly where it dovetailed with content in the Education Standards. However, this change was also felt to be problematic by some. There was some confusion about what registrants are now expected to do and what they should do in an ideal world or if possible. This ambiguity was specifically highlighted by those involved in Fitness to Practise proceedings who felt that it would cause issues with associated decision making.

If all the Standards are something that chiropractors *must* do, then there was significant concern about the sheer volume of requirements and the shift away from minimum standards (and linked to this, the lack of distinction between those Standards that are really important and those that are just desirable). Comments about this aspect of the draft Code were made in relation to all of the Principles, but

particularly focussed on the new Principle H '*Foster collaborative healthcare, effective professional relationships and safe, supportive workplace practice*'. Practical challenges in relation to meeting these standards were flagged, particularly for those registrants working in different settings and relating to the feasibility of collaboration with other professionals.

Some respondents suggested that their concerns would be ameliorated by greater clarity over the key standards registrants '*must*' meet, combined with a reduction in the number of these mandatory Standards i.e. more Standards being designated as those which registrants '*should*' meet or the inclusion of qualifying phrases, such as 'where appropriate'.

There was some concern expressed that the revisions to the Code represent a narrowing of the scope of practice and/or greater prescription in terms of how things are done. This was particularly the case in relation to Principle D '*Provide a good standard of clinical care and professional practice*'. Some felt that this perceived prescription could be detrimental to patient care and could potentially result in an increased number of Fitness to Practise cases (potentially as a result of malicious complaints). The use of the term 'evidence-based' throughout the draft Code served to reinforce this sentiment as it suggested that clinical recommendations must be backed up by published scientific papers rather than evidenced by experience of clinical practice.

There was also some call for greater clarification of specific requirements in relation to the reporting of safety incidents, concerns about colleagues and safeguarding issues. Linked to this, there was some uncertainty about how the draft Code links with employment law (and other legislation, for example that relating to advertising and promotion).

Finally, there was some commentary about the acknowledgement in the Code of the responsibilities of patients (as well as chiropractors) and greater clarity about expectations of chiropractors when ceasing treatment.

2. Introduction

2.1 Purpose of the report

The GCC will respond to the feedback received as part of the formal consultation in the form of a report setting out the consideration given to representations received and any further changes or revisions made to the revised draft Code as a result.

The purpose of this report is to summarise the main feedback received. This analysis and reporting has been conducted by Community Research, an independent research company.

2.2 The consultation

The GCC Code encompasses both Standards of Proficiency and Standards of Conduct and Practice for chiropractors. The GCC last consulted on the Code in 2015, with the Code coming into effect in 2016. Following engagement with the sector, the GCC has now drafted a new version of the Code and launched a formal consultation on the content which ended on the 27th September 2024.

In total, 121 responses were received in response to the online survey; the majority of which were registered chiropractors. Further details on the demographics of respondents are provided in Appendix 5.2. Ten of the 121 responses received were from membership bodies, companies, organisations and charities. A list of those who responded is provided in Appendix 5.1.

The online survey was supplemented by a series of events. Three consultation events for registrants were convened in partnership with the Professional Associations and seven discussion sessions were convened with specific audiences, including Professional Associations, Educationalists, the Royal College of Chiropractors (RCC) and those involved in Fitness to Practise (FTP) proceedings (Expert Witnesses and the chairs of the Investigating Committee (IC) and Professional Conduct Committee (PCC)).

2.3 About the analysis

Responses to the survey were coded as to whether they were a positive, negative or actionable comment. This coding was completed by the GCC and reviewed by Community Research.

By their very nature, public consultations are not necessarily representative of the general population. As they are open access, any individual or organisation can submit their views and those who have an interest in (and who have the capacity to respond) are more likely to participate in a consultation than those who do not. For this reason, the approach to consultation analysis tends to be qualitative rather than quantitative – we are interested in the range of views held and who said what, rather than focusing on the number of responses. The main aim of the analysis is to

explore areas of agreement and disagreement and the reasons given. We have, however, conducted some frequency analysis in order to understand the volume of views and the characteristics of the people with particular opinions.

In terms of the survey responses, it should be noted that not all respondents answered every question and not all responses related to the question asked. Some responses related to other consultation questions and some to issues not explicitly asked in the consultation.

Some of the percentages shown in the charts do not sum to 100% because of rounding.

Some responses included detailed information. It is not possible for us to include this detail in a thematic report of this nature (but the full information is being reviewed by the GCC).

2.4 About the report

This report is structured to provide a thematic overview of the feedback. Views of those who responded to the open access consultation (who are self-selecting and called 'respondents') are distinguished from those who participated in more structured stakeholder engagement events (who are called 'attendees').

Throughout the report, quotes have been included to illustrate particular viewpoints. It is important to remember that the views expressed do not always represent the views of all those who participated in that specific event. The attendees have been aggregated with the exception of the RCC who gave explicit permission to be identified. Quotation attributions by stakeholder type in relation to survey responses are those selected by the individual themselves when completing the survey.

3. Key themes

3.1 Positive feedback

There was positivity about the overall approach to the drafting of the new draft Code and the amount of work and engagement with the sector that has gone into its development. It was commented that the revised Code is long overdue given societal and technological changes since 2016. The renaming of the Code to the Code of Professional Practice was also well received.

> The Royal College of Chiropractors congratulates the GCC on the quality of the work that has contributed to the production of the proposed new Code and the thoroughness of the process it has used to consult on the document…We believe the new Standards incorporated into the proposed new Code will contribute significantly to improvements in the safety and quality of care provided by GCC-registered chiropractors.
>
> Survey response from the RCC

> The updated code represents an appropriate and well written update of the existing one, reflecting changes within healthcare generally, regulation, and issues affecting the profession, with the aim of enhancing patient care.
>
> Healthcare Regulator

The extended coverage of the draft Code was welcomed by some, with specific praise for elements of the new Principle B on Safety and the strengthening of equality, diversity and inclusion (EDI) requirements.

> I think back at the original Code and you look at this Code and you think of the all the elements that are now a part of that in terms of EDI, you know confidentiality information, you know information and data protection, etcetera, all those sorts of things are now part of that framework….So absolutely, it's raising the bar, to be honest.
>
> Educationalist session

> The [named Healthcare Regulator] is supportive of the changes to these standards. This Principle is focused on specific patient safety processes and more specific than the [named Healthcare Regulator] standards which are outcomes focused.
>
> Healthcare Regulator

The strengthened links with the Education Standards were singled out for approval at the Educationalist event.

> I think the fact that these Standards map and sync very nicely with the Educational Standards as well is really strong, and both documents I think can

> be seen to be to protect the public…so you're seeing that continuum from education into professional practice.
>
> Educationalist event

The use of the shared values and links to patient feedback and engagement were welcomed.

The provision of a mapping document where changes can be seen at a glance was felt to be helpful, particularly highlighting those areas which have been strengthened. Although it was noted that this could helpfully also include any specific points that are no longer in the Code.

> And I particularly like…the mapping document where we could compare across the codes. It's really, really helpful and shows areas where you strengthened the code, some of the newer areas that have come in.
>
> RCC event

3.2 Focus on patient-centred care

The explicit focus on putting patients' interests first was praised by the RCC and a number of the other Healthcare Regulators.

> It is good to see the move towards explicit patient-centred requirements, as well as requirements for registrants to be more proactive. These include requiring registrants to:
>
> - ask what matters to the patient (A2),
> - actively look for signs of abuse in children and vulnerable adults (A8),
> - actively identify and control risks (B3),
> - raise concerns about unfair or discriminatory behaviour by others (C12), and
> - to take action in response to inappropriate behaviour, particularly the explicit reference to inappropriate behaviour towards colleagues, as well as towards patients (H5).
>
> Healthcare Regulator

> The [named Healthcare Regulator] welcomes the patient centric updates to the Principles and the inclusion of wellbeing outside of more narrow definitions of health. The focus on actions rather than attitudes is in line with the [named Healthcare Regulator's] own updates to our standards of conduct, performance and ethics.
>
> Healthcare Regulator

3.3 Minimum standards or aspirational approach

A point raised extensively in the consultation feedback related to the intention behind the Code and whether it aims to set basic, minimum standards that chiropractors must adhere to or it is aiming to be more aspirational. This was

compounded by some confusion over the use of language, specifically 'must' and 'should' as discussed Section 3.4.

It was queried whether a chiropractor, by not meeting these (higher) standards, could be sanctioned if the Code is aspirational and that this has implications for future Fitness to Practise processes.

> I always think every point, every line, should be a question. You know, what's the Fitness to Practise question on the back of that issue?
>
> Professional Association event

> To a large extent the new Code is not setting a minimum standard for registrants to meet but is rather aspirational in nature which is unreasonable and likely unachievable by the average registrant.
>
> Survey response from Individual Chiropractor

> I think it is not clear sometimes what the threshold is for a breach of the Code. Some Standards are very clear and prescriptive. Others seem to be straying into minor issues which in and of themselves would be unlikely to reach the threshold for unprofessional conduct.
>
> Survey response from Educationalist

It was mooted that the Code is not the best place to think about best practice and the more aspirational 'gold standard' (which could be done in education or by the RCC).

> This particular point with A8 is that we are being expected to, I think, go beyond what is our scope of practise, what is our training, and I don't think the right approach…Okay, we are putting it into educational institutions, we want to build this skillset within the profession, that's from the bottom up; that makes sense. Right? But then top down, that means that every chiropractor is then held to this standard which they may not be trained or skilled to do.
>
> Individual involved in FTP proceedings (at event)

> So, with the nature of regulation as it is currently accurately identified above is to set the minimum acceptable standards, the essentials, however we feel like the general proposed Code that follows contradicts this intention by going above and beyond the minimum regulatory requirements, straying a little bit too far maybe into best practice and gold standard
>
> Professional Associations event

There was a call for the GCC to consider the impact of the changes to the Code as a whole and ensure that they are not placing too much burden on chiropractors, particularly those working in single practice. It was felt that the communication of requirements in relation to the Code is key.

> It does cut out the low standard chiropractor that actually causes us concern. That's what it does. It helps with that and it gives you the Standards for it. I just would be very conscious of that middle level chiropractor who is working on their own and this gives them an extra burden that maybe causes them some concern, and how that is communicated to them…It's a standard that they should be meeting anyway rather than a burden, if you understand me.
>
> Individual involved in FTP proceedings

Linked to this, others also called for the draft Code to be stress tested considering the impact on those working in different settings and circumstances.

There was some mention that the Code is longer than previous versions and there is some perceived duplication across Standards.

> I just think that sometimes the desire when you're writing a new draft of something, it feels like you need to sort of create more out of it for more clarity, but sometimes more clarity comes from doing less.
>
> Professional Association event

It was questioned whether the changes to the Code are in response to the profession being perceived as 'unsafe' and whether the expansion of the Code is proportionate. Two Professional Associations commented that there is a sense that the introduction to the Code sets a negative tone and some individual chiropractors commented in a similar vein.

> It would perhaps also be welcomed if there was an acknowledgement that the vast majority of chiropractors have met and exceeded Standards within past codes, and this is an evolution of that.
>
> Survey response from Professional Association

> It does seem to make the assumption that chiropractors are unsafe. There are about 40 million chiropractic patient encounters every single year. There is very little that comes out as being chiropractors are unsafe. So the force behind this does seem a bit misplaced to me anyway.
>
> Individual involved in FTP proceedings (at event)

3.4 Clarity over 'must' and 'should'

Attendees at a number of the sessions and some survey respondents felt strongly that the Code could be clearer about what are things that chiropractors must do as opposed to those that they should do, relating back to the overarching point about minimum standards versus aspirations. There was some sense that this aspect was clearer in previous versions of the Code. There was evident concern about this perceived confusion and the implications for how the Code would be used in both Fitness to Practise processes and education.

A Healthcare Regulator's survey response noted that there was strong support in consultation feedback on their standards for the continuing use of '*you must*' and '*you should*'. This was regarded as a well understood signal about the expectations for each specific duty set out in the guidance.

Some of this uncertainty appears to be a result of formatting issues in the version of the Code that was consulted upon[1].

> We must use outcome measures, so we're saying these are 'musts' because for me I wouldn't necessarily, although it's things chiropractors should do, is this the threshold of minimum standards or are these more?
>
> Educationalist event

> Often in Fitness to Practise determinations there are individual Standards that had very specific points. But sometimes it was a more general issue and what you could do is you could go to the introduction of the Principle and it says, right, chiropractors *must* look after patients, or whatever, and that was quite useful…. So some places it's caught, but I'm just worried in a few places that there are things missing from that.
>
> RCC event

> I've written disciplinary civil criminal reports using all four iterations of previous regulatory frameworks, I don't think I could do so using this one because there is no imperative anywhere in any of the Standards. So it doesn't say chiropractors *must*, chiropractors *should*. Some of the statements appear to be aspirational.
>
> Individual involved in FTP proceedings (at event)

If all the Standards are something that chiropractors must do, then there was concern about the sheer volume of requirements and the shift away from minimum standards (and linked to this, the lack of distinction between those Standards that are really important and those that are just desirable). This links back to the debate about which standards are aspirational here.

There were mixed views on whether there is room for 'should' in the Standards or not. Some felt that the inclusion would cause issues but others that it offered a way of distinguishing between Standards that are non-negotiable and those that chiropractors should endeavour to meet (but that they will not be penalised if there is good reason that they cannot).

[1] The overall introduction to the consultation version of the Code does state that all Standards are 'musts', unless otherwise indicated, but this was not identified by some respondents as it was not repeated in the introduction to each Principle..

> I always think the 'musts' is clear, that's what you have to do. I think the 'shoulds' are important in terms of you should be doing this unless you've got a good reason not to. And there might be a jolly good reason not to do something. But if you are putting everything as a 'must', then we are talking about putting people into a situation where there is an FTP situation and there is no defence.
>
> Professional Association event

> You either take out all the 'shoulds' so it's a much smaller Code of 'musts' and you put those 'shoulds' into best practice, and then it's really, really small and clear. Or…you put the 'shoulds' in as 'shoulds'. At the moment it's gold standard and, because there is no 'shoulds', it's all gold standard as a 'must'. So I think either take out the gold standard and have it as a minimum standard, or pile in a load of 'shoulds'. But at the moment it doesn't actually do either.
>
> Professional Association event

There was some discussion about whether the intention is to return to the ethos behind previous Code versions.

> Well it's trying in many ways to do what the 2010 Code used to do. It had a regulatory framework with fairly brief and fundamental Principles, and then it had a separate section that demonstrated how chiropractors could best fulfil these. And I think what it's trying to do is take a fundamental Principle: showing respect, compassion and care for the patient, and then include within the regulation what a chiropractor *must* do as opposed to *might* do or *should aim* to do. And therefore you are bringing it into the UPC framework rather than perhaps separating the fundamental core requirements of a chiropractor and how they can best fulfil these.
>
> Individual involved in FTP proceedings (at event)

3.5 Relationship to other healthcare standards

The other Healthcare Regulators who responded to the consultation were largely positive about the changes to the draft Code, commenting that they are in tune with current developments in the sector and with their own thinking/revisions to their own guidance. This was particularly the case with newer standards introduced in relation to patient-centred care (see Section 3.2), but also relating to registrant proactivity, safety, new technology and EDI.

> We note the proposed ten Principles which feature in the Code (Principles A-J) and we welcome the reflection of the findings of our review of [named own Standards] in the following areas where new standards have been created – Principles A, B, C, D, G & H
>
> Healthcare Regulator

However, it was queried by others whether the GCC was holding chiropractors to higher standards than those required by other healthcare regulators. It was also pointed out by some that, whilst the changes made to healthcare professions' standards more widely should be considered, the Code should not just replicate what is in the guidance of other regulators given the very different nature of chiropractic.

> Of course, if another regulator has brought in a new point to their regulatory code of course the GCC should consider it. It would be foolish not to. But to automatically include it simply because it appears in some other healthcare's regulation and however irrelevant it is to chiropractic; I think is wrong
>
> Individual involved in FTP proceedings (at event)

> There appears to be an inordinate number of Principles to be adhered to, many of which are doubling up on others and are therefore superfluous. More regulation and regulatory principles do not equal better regulation and enhanced patient safety, only more confusion for registrants and patients. When compared to the GMC and GOsC documents, we appear to be overly zealous in our chiropractic regulation and being able to micromanage our registrants in this way will not be conducive to better standards.
>
> Survey response from Professional Association

Linked to this, a general point was made that the Code needs to reflect the fact that chiropractic care is generally a paid for service rather than accessed through the NHS. Those having treatment may see themselves as customers rather than patients and this nuance needs to be considered in the Code.

3.6 Perceived narrowing of scope

There was some concern expressed that the revisions to the Code represent a narrowing of the scope of practice and/or greater prescription in terms of how things are done. Some felt that this could be detrimental to patient care and could potentially result in an increased number of Fitness to Practise cases (potentially as a result of malicious complaints).

> We understand that obviously patients have to be protected but if it gets to that point where we're narrowing the scope to such an extent that actually they're not actually getting what they should be getting, or we're not delivering what we want to deliver in the best interests of the patient, then could that be detrimental to the patient even though we're protecting them.
>
> Professional Association event

> And looking at the new Code, that seems that may almost open up the door to more of that if you just simply don't like the way somebody practises down the street. What reassurance can you give to the registrants that that's not the case or indeed is the case?
>
> Professional Association event

> So we need to be very mindful that, if we have a Code that seems to be placing a massive spike in terms of regulatory obligations, then be ready for the avalanche of complaints that will follow that; not all of which will be justified.
>
> Individual involved in FTP proceedings (at event)

A small number of respondents to the survey expressed concern that the Code was drafted in such a way as to favour those practising certain types of chiropractic care. References to 'evidence-based' care served to reinforce this view (see Section 3.9). A very small number of individual chiropractors indicated that they may consider leaving the profession as a result.

> Myself and other colleagues are suspicious about this Code revision. On the one hand there are many laudable aims and additions to the Current code. On the other hand many of us fear that the sections with regard to 'evidence' are disingenuous, and are included for ulterior motives.
>
> Survey response from Individual Chiropractor

3.7 Legislative requirements

There were a number of comments in relation to how legislative requirements are referenced in the Code typically centred around the following two points:

- A sense that the expectations of chiropractors' knowledge of legislation are onerous and that requirements could be clearer and more specific. There was some strength of feeling about this from the survey responses. It was felt that other healthcare professionals would not be expected to be familiar with the GCC Code.

> It [C3] sort of talks about the fact that we should be knowing about other regulators' codes as well. I just kind of wanted to confirm. I'm getting the flavour from this call that it's kind of a spirit of professional behaviour rather than necessarily the specifics, but that reads very much like you want registrants to read all the other regulators' codes.
>
> Professional Association event

- Some confusion about how Code is linked to the statutory requirements, particularly in relation to employment law and advertising/promotion.

> I believe employees would fall into employment law and is not within the remit if the GCC. I would hope that if a staff member did not adhere to this Principle [E2] that the patient would first seek help from the employer or the chiropractor, who could then investigate and take appropriate action through appropriate employment law.
>
> Survey response from Individual Chiropractor

3.8 Precision of language

There was some praise for the work that has gone into trying to ensure that the new version of the Code is clearer in terms of the expectations of registrants.

> I think it's a vast improvement. There were lots of very wishy-washy comments in the past that are made very specific here. There are comments when we go through it, but in broad terms I think it's a vast, vast improvement.
>
> RCC event

However, there was a call at many of the sessions for greater precision in terms of language and phraseology used.

> If we as a group, are having to thrash this out and have a conversation, about what does that really mean, then the Code needs to be clearer because when we teach it, people go well what if it's this and what if it's that and we can't answer it?
>
> Educationalist event

> I do think an awful lot [in relation to Principle A] of them are frankly waffly. And I'm putting my expert hat on here and thinking, you know, if I'm trying to establish whether there was breach of duty of care for a civil case, if I'm trying to establish whether the actions of a chiropractor fell considerably below the standards expected…There is so many things there that you just can't measure.
>
> Individual involved in FTP proceedings (at event)

There was some debate around the use of the 'evidence-based' in the document and the implications of this for the profession and practice on the ground. This is discussed further in Section 3.9.

There are some specific terms like 'thorough case history', 'complex health and social circumstances', 'near misses', 'concerning behaviour' and 'emotional' boundaries that were felt to be open to interpretation. There was a call for the glossary to be reviewed to check that it is comprehensive.

> "A near miss is an event that almost causes harm or damage but doesn't fully happen." I mean a more woolly phrase one couldn't ask for, could we?...Almost causes harm. What's harm? What's damage? It didn't fully happen. It's so ephemeral. It's fodder for the lawyers, isn't it, not for the chiropractor?
>
> Professional Association event

Interestingly, at the Expert Witness session there was a point of view that sometimes it can be useful to use terminology that allows for some interpretation. The example of 'thorough' case history was given at D1.

> Can we just head back into 'thorough' because I picked up on 'thorough' too. I thought to myself that was very black and white. It had absolutely no grey to it. I would prefer to see something along the lines of 'close' because 'close' in its definition actually means careful and thorough.
>
> Individual involved in FTP proceedings (at event)

3.9 Use of the term 'evidence-based'

There was some debate at many of the sessions and in the survey responses around the use of the 'evidence-based' in the document and the implications of this for the profession and practice on the ground i.e. does it mean clinical recommendations must be backed up by published papers or can they be evidenced by experience in clinical practice and substantiated using outcome measures during progress examinations? This was also raised in relation to advertising standards which is discussed more in Section 3.10.

> I think the issue there is that you've got those definitions of evidence that make so much sense and they're all based on Sackett. So the idea essentially is that you've got the best available evidence, the patient's needs and wishes, and your skills and experience, and I think everybody would completely subscribe to that from a patient-safety perspective. But then, on the back of that, you've got the acceptable quality of evidence side that suggests that there needs to be, you know, meta-analysis or RCTs. Well that then negates clinic audits or clinical reflection, or what you see in your practice or what you find that works really well for certain patients within your practice. And certainly that then stifles practise. And it's those little bits of definition, which

> from an academic perspective again I think we are all behind, we want to do the best we can do, but actually practically that is a concern.
>
> Professional Association event

> There is a lot of reference to evidence-based, you know, guidelines without being specific. It sets the tone that we are using invalid and poor examination techniques. I mean it doesn't seem to be referencing practitioner experience. Because earlier in the document it seems to minimise practitioner experience. So it's repeated multiple times. So I'm just wondering what the intent is on that.
>
> Individual involved in FTP proceedings (at event)

> Evidence-based is used multiple times within the document and Principle D. However, the tone is that Chiropractic practice inherently lacks evidence which is not the case in the true meaning of the statement. There needs to be explicit acknowledgement as in the existing Code that practitioner and patient preference is part of evidence-based care.
>
> Survey response from Professional Association

Two Professional Associations suggested the use of the term 'evidence-informed' as the base expectation for registrants. It was felt that this allows for the use of evidence to be part of the Standard, but also acknowledges there is a lack of breadth and depth in chiropractic evidence due to the relatively young age of the profession.

3.10 Advertising and promotion

Advertising and promotion of services was identified as an area of concern fairly broadly. Clarity over what chiropractors can promote and the guidance that they should adhere to (GCC and/or Advertising Standards Authority (ASA)) were specific issues raised. A Professional Association's response to the survey specifically called for the removed guidance from the 2016 Code to be reinstated to avoid an increase in queries regarding compliance.

> 'Advertising services/promoting your business' is the number one concern from [named Professional Association] members regarding the new Code of Professional Practice. However, much of the guidance from the 2016 version of the code has been removed. The [named Professional Association] suggests that the removed guidance is reinstated to avoid an increase in queries regarding compliance.
>
> Survey response from Professional Association

The relationship between the ASA Standards and the GCC code was also queried at a number of sessions i.e. if chiropractors are not adhering to the GCC Code if they do not follow the ASA code. There were a number of questions that centred around

the perceived divergence of guidance between the ASA and the GCC; specifically a perception that the ASA requires scientific evidence of any claims made in relation to marketing services whereas the GCC has a broader definition of the evidence that they would accept to substantiate claims. This was felt to lead to a potential situation where the GCC would be happy with the content of specific adverts or promotions but they may be in contravention of ASA guidelines or rules.

> The GCC 'allow' us to treat conditions that are not yet 'proven' by science... but the ASA won't like it. Will the GCC support our treatment against the ASA?
>
> Professional Association event

> I think the advertising issue has to almost be spelt out because I think it's such a big issue with registrants that it probably has got to be a bit more specific.
>
> RCC event

Some questions related to what the GCC perceives as suitable evidence for claims, with examples given of whether they can promote treating patients with headaches or whiplash injuries.

> Can I advertise that I can treat whiplash on my clinic website if there is moderate quality evidence for it (e.g. for multimodal care)?
>
> Professional Association event

The use of the word 'verifiable' in C4 was queried as part of the RCC discussions with the concern that it might be too stringent a term in relation to evidence-based practice.

Concerns about being sanctioned for misleading claims was linked to chiropractors being inhibited from marketing their services fully and having a detrimental impact on the business (particularly for newly qualified chiropractors). Clarifications were also asked in relation to the responsibilities of chiropractors who are not themselves responsible for the marketing at a clinic at which they practice

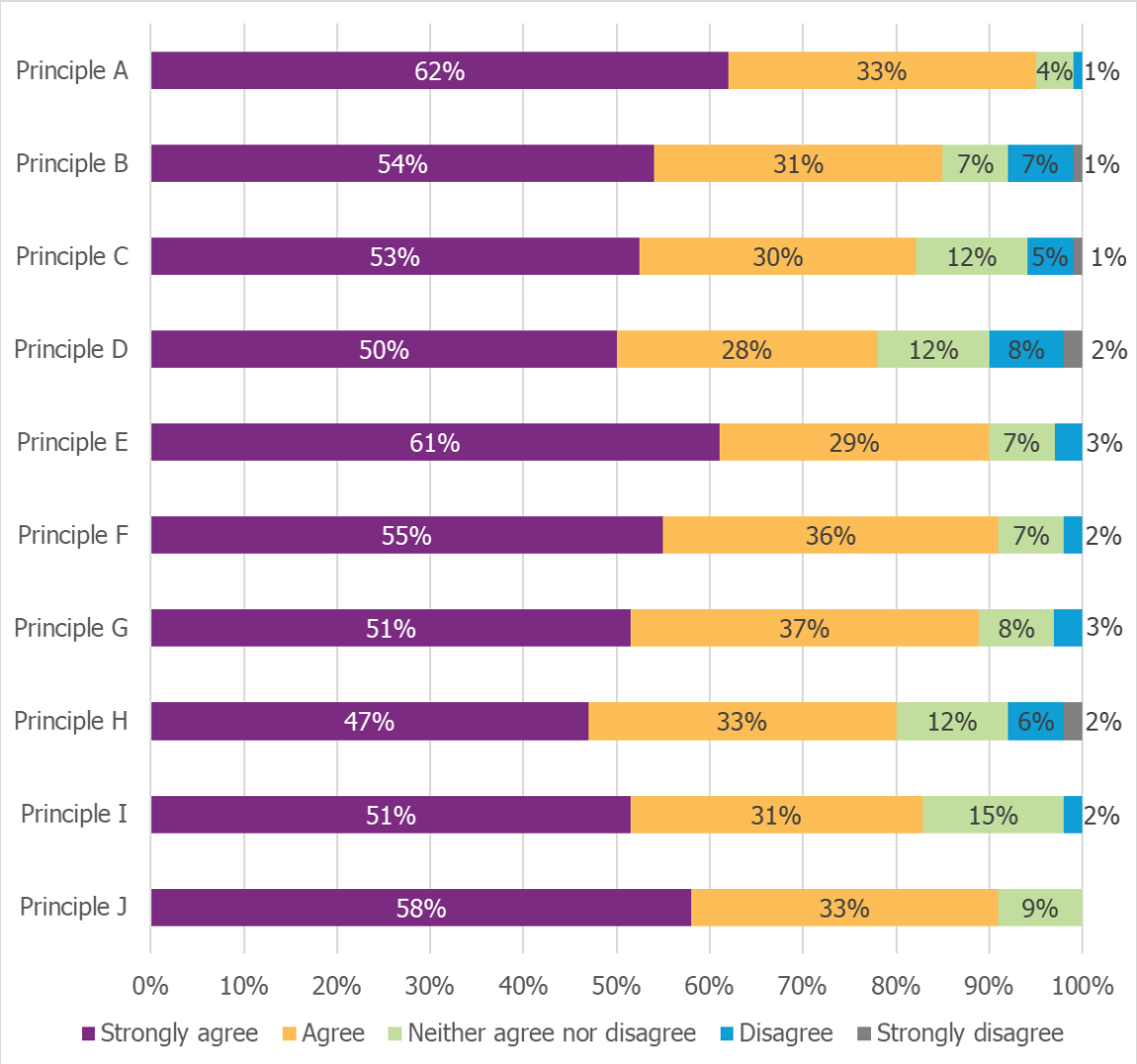
It was also questioned whether the GCC Registrant Guidance on Advertising (2021) remains applicable.

4. Feedback on specific aspects of the Code

4.1 Overall response to Principles

For each Principle, survey respondents were asked *'to what extent do you agree or disagree that the Standards describe the minimum expectations that must be met by registrants in relation to this Principle?'*. Overall there were high levels of agreement for all Principles. Lowest levels of agreement were for Principles D and H (with 78% and 80% agreeing respectively). This reflects the debate at the events/discussions which tended to focus on these Principles.

Figure 1 - To what extent do you agree or disagree that the Standards describe the minimum expectations that must be met by registrants in relation to each Principle



Base: 121 respondents

More detail on the views on the Principles by stakeholder type is provided in Section 5.3.

The Principles that are earlier in the Code tended to receive more survey comments than those that came later, with most comments centred around Principles B, C and D. Principles F, I and J received comments from fewer than 20 respondents.

Just under half of survey respondents answered the quantitative questions but had no specific comments on detail of the Principles and Standards.

4.2 Principle A – Put the interests of patients first

The patient centred focus of this Principle was welcomed by the RCC and Healthcare Regulators with some noting that updates are in line with other regulators' guidance.

> The RCC welcomes the broadening of Principle A to all aspects of patient interests and the increased emphasis on safety and patient-centredness.
>
> Survey response from the RCC

> This [putting the interests of patients first] is reflected in the proposed review of the Code introducing new standards which demonstrate working in partnership with patients. Standard A3, to engage effectively with the patient through person-centred conversations and interactions and the shared decision-making standard at A4 work with the collaborative standards set out at A5.
>
> Healthcare Regulator

There was also positivity about the broadening of patients' interest to include wellbeing and the requirement for greater proactivity. However, some survey responses, including from a Professional Association, commented that they felt that the Principle should state a patient's *health* interests rather than interests more widely given that this is what chiropractic care is focussed on. There was also commentary about the balance between patient interest and the chiropractors' own interests and wellbeing. It was felt that there should be a better reflection of the reality of practice, consideration of different scenarios and it should be couched in terms of the patient/practitioner relationship.

> Ultimately it must be recognised that chiropractors are humans too and have limitations as to what they can cater for. The Code must consider what is reasonable, proportionate and practical.
>
> Survey response from Individual Chiropractor

Responses highlighted that sometimes patients are not rational in their decision making and that there is a need for chiropractors to help lead, guide and advise.

It was pointed out in survey responses and discussions that A5 '*Collaborate with the patient's family, advocates, carers, healthcare professionals…*' needs to specify that there is a requirement for the patient to consent to this collaboration. It was also queried how chiropractors should prove they are collaborating and whether they

would have the expertise to do so. This Standard generated a relatively large number of comments in the survey.

> It's a very good example of something that is effectively aspirational, being, as you say, a must. So you must collaborate with the patient's family, advocates, carers and healthcare professionals…Well what about if that isn't practical? What about if the patient doesn't want you to?
>
> Individual involved in FTP proceedings (at event)

A6 states '*Respect the patient's privacy, dignity and their right to choose who is in the room when their care is provided*'. It was noted that not all care is provided in a treatment room and that this should also be widened to relate to discussions about care and not just treatment. It was also highlighted that there may be occasions where the chiropractor might want someone else in the room for their own protection but this may conflict with the patients' preferences (and the interpretation of subsequent Standards in the Code). This discussion is linked to that relating to chaperones in Section 4.6.

> It [A6] is phrased very clearly that the patient has a right to choose who is in the room, but later in the Code it suggests there needs to be reasonable discussion as part of determining informed consent.
>
> Survey response from Individual Chiropractor

The vast majority of attendees of one of the Professional Association sessions did not work in open plan clinics. However, there were a number of questions at this session around how 'open plan' treatment would be defined in the Code and what the thinking is around specific guidance/requirements in this respect. This was also queried at RCC discussion:

> I searched for the words 'confidentiality' and 'privacy' and actually didn't find it in many places, and didn't find it obviously in the context of open-plan practice. Now, I don't know whether the GCC is trying to make a point about open plan in this document. I don't think it's made very firmly, to be honest.
>
> RCC event

However, another Professional Association commented that they felt that this Standard has implications for practices that use 'open plan settings'. It was suggested that private spaces should be made available for any discussions, but that registrants should not be expected to change their treatment arrangements and that patients who are not comfortable with this, could seek alternative providers.

The content of A8 in relation to safeguarding children and vulnerable adults was specifically welcomed by a Healthcare Regulator (alongside other Standards which require greater proactivity by registrants; see Section 3.2). A number of individual chiropractors also indicated that the requirement in relation to A8 is in tune the

current education curriculum and responsibilities relating to providing information to individuals. More signposting and guidance in this respect was requested.

However, the Standard was also highlighted as potentially problematic at the Expert Witness session and in responses to the survey. Assessing vulnerability and actively looking for signs of abuse was felt to be outside the scope of many chiropractors' expertise. It was another example of what could potentially be a 'should' rather than a 'must'.

> This Standard [A7] is clearly an evolution of the previous Code; however, we believe its modification and broadening has serious ramifications for a registrant.
>
> Survey response from Professional Association

> A fundamental tenet of the Code is that chiropractors should practise within their knowledge and abilities, and this seems to absolutely fly in the face of that for the majority of graduated chiropractors.
>
> Individual involved in FTP proceedings (at event)

It was also queried what '*local* safeguarding arrangements' are in the context of NHS and care services.

A Professional Association suggested an addition to A2 about outlining treatment options to patients, to expand their understanding outside of chiropractic. Responses from two Professional Associations and discussion at the expert witness session suggested A2 should read 'undue' pressure on a patient as a chiropractor should be advocating a specific course of action or focus on chiropractors, showing leadership in having patients accept their advice.

4.3 Principle B – Ensure safety and quality in clinical practice

In general the introduction of new Principle B was welcomed, in particular by the RCC and Healthcare Regulators.

> The standards at B4 and B6 recognise the importance of supporting the promotion of accessible healthcare and the collection of feedback to evaluate the quality of patient care which contribute to patient safety.
>
> Healthcare Regulator

> We welcome the new principle B around ensuring safe settings for patient care, an aspect which is particularly relevant to chiropractors who will typically be responsible for the treatment setting.
>
> Healthcare Regulator

However, some concerns were expressed about the proportionality of the requirements and the perceived disproportionate burden that it would place on the

profession. This was the view of two Professional Associations and some individual chiropractors who responded to the survey. There was a view that GCC has applied similar Standards to those used by other Healthcare Regulators but that this does not take account of the context and settings of chiropractic care. Other commentators felt that elements of the Principle were ambiguous and called for greater clarity.

> The values that permeate through this Principle are well placed but the execution in several Standards potentially set the bar too high and we feel places reasonable registrants at real risk of complaint.
>
> Survey response from Professional Association

> I question the unreasonable burden placed on a profession that has an excellent safety and customer satisfaction history. We are a small profession with limited resources.
>
> Survey response from Individual Chiropractor

In relation to the new Principle about safety and quality, there were specific questions about [B6] which states that chiropractors should 'apply quality management Principles to continue to improve your practice and service delivery'. More detail was requested about how GCC would see themselves monitoring this and if there are specific expectations in relation to how the practice effects this.

> I wondered if you could give an example of how the regulator would see themselves monitoring that and what that would be? Is there a defined quality tool that is being used there in terms of the management of the practice? And if you could explain how that specifically relates to the safety and care of the patient?
>
> Professional Association event

It was felt that the B6 statement '*collect appropriate feedback, quality and other indicators to evaluate the quality of care of your patients*' should specify quality indicators. It was also suggested by an Educationalist that there could be further guidance on how to collect feedback and that the GCC should ensure that the requirements in this respect aren't too onerous or unfeasible for those working in small practices.

Linked to this, it was also queried what is meant at B5 when there is mention of incident reporting and what is meant by a 'near miss' and 'suitable safety system'. Some asked whether there is an expectation that chiropractors will record very small issues and whether practices will be mandated to use CPiRLS. Others queried if there needs to be a clearer definition of what a 'suitable safety system' actually is i.e. could an email to management or a note to self be sufficient if it led to no specific outcome or prospect of wider learning?

> The RCC welcomes the intention to require registrants to report safety incidents and near misses so that other chiropractors can learn from the collective experience in the best interests of patient safety. However, safety incident reporting systems must be seen as non-threatening, safe places to share experiences for the purpose of risk management/learning only, otherwise they are not trusted. Anonymity is a vital component of this and so it may be unrealistic to REQUIRE incident reporting via a Standard in the Code.
>
> Survey response from the RCC

> If reporting is to be a regulatory requirement, please outline the recommended method, e.g. CPiRLS. Consistency with Standards set by the Royal College of Chiropractors would align expectations across the profession and therefore make it easier for a chiropractor to meet these Standards.
>
> Survey response from Professional Association

At the RCC discussion and in the survey response, it was flagged that specific mention should be made of requirements relating to first aid (at B3 and in Principle I). At the session with Professional Associations, clarification of what 'emergencies' refers to in this context was requested as it could be fairly broad. Two Professional Associations raised an issue with B3 in terms of the requirement to 'control' risks and requested a rethink in terms of what were reasonable expectations of registrants and for examples.

It was mooted that in the title, the word 'quality' should be replaced by 'competency'.

> Yes, I'm saying that competency is more relevant to chiropractic and chiropractors, as opposed to quality which is about a professional standard, which is collaborative.
>
> Individual involved in FTP proceedings (at event)

There was some suggestion in survey responses that this Principle should also recognise the importance of the safety of practitioners (linked to ceasing treatment which is further discussed below).

4.4 Principle C – Act with honesty and integrity and maintain the highest standards of professional and personal conduct

The expansion of this Principle was broadly welcomed by Professional Associations, a Healthcare Regulator and a number of individual chiropractors.

> The standards at C11 - to ensure personal biases, values and beliefs do not detrimentally impact the care provided to patients - and then followed by a duty at C12 - to raise concerns about colleagues if there is a belief that they are treating people unfairly, have discriminated against someone or if their

> personal biases have detrimentally impacted on the care they provide – are an acknowledgement of an awareness in this area which is welcomed.
>
> Healthcare Regulator

However, other individual chiropractors responding to the survey were concerned about its length and level of detail. Again, there were comments about the level of aspiration and some of the perceived onerous expectations on chiropractors i.e. checking that colleagues are registered [C2] particularly for those working in multidisciplinary settings and responsibility to protect others from harm caused by the health, conduct or performance of you or any other regulated healthcare professional [C1]. Some felt that the Code was being written from a standpoint that the profession is not trustworthy and inherently dishonest.

> I feel the Principle is too long with too many Standards. This impacts its accessibility and will be a barrier for chiropractors, students, patients and any other stakeholders to engage with it. Perhaps some Standards could be merged.
>
> Survey response from Individual Chiropractor

C5 on the credibility of health information was welcomed by the RCC and a Healthcare Regulator. The latter felt it may be helpful to clarify that sharing information which is not evidenced based, even when not considered health information, can be damaging to the reputation of the profession. However, others saw this as duplicating C4 and as problematic (linked to the discussion of 'evidence-based in Section 3.9).

> This is probably the biggest bone of contention. A large section of the UK profession feels that this Principle will be used to target chiropractors who offer proper treatment plans with FTP hearings.
>
> Survey response from Individual Chiropractor

Another Healthcare Regulator felt that C4 could also possibly be strengthened further:

> The phrase 'when telling people about your services' may not fully capture the GCC's published position[2] on reviews, testimonials and endorsements. The phrase may be interpreted to mean the requirement only applies to information provided directly by the registrant, when the GCC's blog suggests it also applies to information provided on their behalf.
>
> Survey response from Healthcare Regulator

[2] Reviews, Testimonials and Endorsements - the GCC reminds registrants of their responsibilities | GCC (gcc-uk.org)

'Behave with integrity, act professionally, and honestly, upholding the reputation of the profession and justifying public trust, *in all aspects of your life'* [C6] was felt to be an overreach by some, and potentially result in spurious Fitness to Practise complaints.

It was commented that there is perceived dissonance between the GCC's guidance [C10] and regulatory requirements with Duty of Candour and what you are told by the insurance company when you report a complaint, which is not to offer an apology because it's seen as an admission of guilt.

C14 about concerns about a chiropractor's own fitness to practise could include reference where support is available from and consider adjustments rather than automatically stopping practising.

At the Educationalist session and a number of survey respondents queried whether and how C15 [informing regulator about a dismissal] applies to anyone dismissed by any employer, for example someone dismissed from a university in relation to teaching rather than clinical competence or someone dismissed from an employer because of a personal dispute. It was also questioned how this applies to those who are self-employed and not safe as they wouldn't be dismissed in the same way and whether the duty is on the employee or employer. Finally, it was queried what 'refused membership' means in this context and how the GCC will use this information.

Care and finance plans

At a Professional Association session, there was some concern expressed about clinics that encourage patients to sign up for multiple future treatments at the first session and questions about how this sort of practice would be dealt with in the new version of the Code. Offers such as Groupon in absence of a care plan were also mentioned at Educationalist session. It was felt that this type of selling is detrimental to the profession's reputation as a whole.

> These practices that pressure patients to sign up for 20+ treatments are a disgrace! It is the main complaint about our profession that I hear from GPs!
>
> Professional Association event

As a result some welcomed C9 '*Determine and share a clinical plan of care for the patient separately (and independently) from any financial payment plan*' and felt it was an important addition. However, others flagged that it could be perceived negatively externally and have an adverse impact on the reputation of the profession as a whole.

> I think if someone looking at that from other healthcare profession, I think that views us in a very negative light, I don't know it is there. Is there a way to change that or to shape it?

Educationalist event

> This is a welcome evolution from the comments on the registrar's blog earlier this year and we welcome the acknowledgement that financial plans are used and can be beneficial in improving access to care for patients.

Survey response from Professional Association

Whilst there was a call for the Code to be strengthened in this area, it was also pointed out that there does need to be some balance in that any changes do not prevent chiropractors offering discounts or loyalty schemes that would make treatment more affordable and/or adversely affect them as a business.

In response to the survey, some individual chiropractors felt that it was unnecessary to separate conversations about care and payment plans are they are so interrelated. '*Do not offer a financial payment plan that extends beyond the amount of care set out in your initial clinical plan of care for the patient'* was particularly contentious. Some, including a Professional Association, felt change was unnecessary as long as refunds are available.

There was a call for more direct, clearer wording:

> I think what this piece of the Code is trying to say is, look, you shouldn't be getting patients to pay upfront for 100 treatments right at the outset if you don't know how the care is going to progress. I think that's the intent from previous FTP cases. But I just wonder whether the wording needs to be slightly more direct in relation to that, if that's what the intent is.

Individual involved in FTP proceedings (at event)

Ceasing treatment

Issues relating to how to cease treating patients [C13] and how to do this within GCC guidelines were discussed. More detail on how the GCC is intending to approach this was requested.

At a Professional Association session, attendees were asked to respond to a poll question which asked, '*Have you been involved in a situation where you have felt that your safety, or that of a staff member, was at risk from a patient*?' Just under half indicated that this had been the case (with some querying whether female chiropractors were more likely to experience this than male). Some described experiences which had been very upsetting and disturbing.

Concern was expressed about this issue at the session with Professional Associations and in the survey responses from two Professional Associations and some individual chiropractors, with a strong call for clarity that chiropractors could cease treatment if they feel at risk from physical, verbal or sexual harassment and not have to fear being in contravention of the Code. The point was made that GPs are able to cease

treating patients in these circumstances and there could be some learning from how this is handled in the GMC's Standards.

> It's OK to stop treating a patient if you are feeling under threat, it needs to almost have explicit permission in there. I think for our members to feel safe in doing that, it might be like an NHS line that there is zero tolerance against, but I feel that needs to be more explicit.
>
> Professional Associations event

Further clarification of the following was mentioned:

- Who to report the patient to i.e. should the police be involved?
- How the GCC would respond if the chiropractor refused to find an alternative practitioner when halting the provision of treatment (as is stated in C13[3])? It was felt that there could be some circumstances in which they would not wish another practitioner to experience the issues that they had had with the patient.
- If they would be justified in refusing care if the patient is in significant debt to the clinic or if they behave in a racist way (with the suggestion of some qualifiers about this in C11), together with scenarios when it would be acceptable to cease treatment.
- Support with communicating the end of treatment, specifically for those who are concerned about the patient response.

The Code states that chiropractors should '*justify and record your reasons for refusing or discontinuing care for a patient'*. It was mooted that 'support' or 'explain' would be a better term than 'justify' in this instance.

4.5 Principle D – Provide a good standard of clinical care and professional practice

The other Healthcare Regulators were largely positive about the new elements of Principle D.

> We also welcome the tweak to D4 which now refers explicitly to the use of diagnostic imaging…We recognise that the final clause of new D13 (*Support public health initiatives to enhance the health and wellbeing of others*) may come out of the experience of the pandemic, and welcome its inclusion here.
>
> Healthcare Regulator

> We also note the proposed new standards at D13 to D15 regarding clinical care and professional practice, and recognise that the standards are working to the benefit of public health, acknowledging the use of digital technologies in practice enhancement and the use of research in practice.

[3] Explain, in a fair and unbiased way, how they can find other healthcare professionals who could offer care.

Healthcare Regulator

> The [named Healthcare Regulator] welcomes new standards which recognise the role of all health and care professionals to play a role in preventative healthcare and to engage in evidence-based practice.

Healthcare Regulator

Principle D was one area where it was felt by some, including two Professional Associations, that there was too much prescription – that requirements were too onerous and aspirational. There was some feeling from individual survey respondents that this Principle is predicated on a medical model and does not take account of the different types of chiropractic care (and how it differs from other forms of healthcare).

> This Principle as a whole does not reflect chiropractic practice. Many of the Standards are not applicable to chiropractic. It seems like some of the Standards are lifted from a different profession altogether…. If you were catering to only chiropractors who practice completely in a medicalised model, you would be bang-on. But unfortunately, you are not catering to the majority of the profession.

Survey response from Individual Chiropractor

Three Professional Associations and an Educationalist queried the use of 'scope of practice' in the introduction and the latter felt that relevant clinical guidelines are not always available. Linked to the latter point, there was some debate about the use of evidence-based (as per Section 3.9.) Some welcomed the use of the term throughout the Principle. For example, at the Educationalist session, it was questioned whether the wording at D6 'In partnership with the patient' puts too little emphasis on the responsibility of the chiropractor. At D8 '*Do not propose a plan of care that is not justified by a robust, recorded, clinical assessment and reassessment'*, it was queried whether there should be some additional reference to evidence-based. However, others felt that the definition of evidence-based does not take sufficient account of practitioner experience:

> There is very little attention in section D to the importance of basing a good standard of care on valued clinical chiropractic experience and empirical knowledge from case studies in an office and the wider community of chiropractors.

Survey response from Individual Chiropractor

It was mooted that if 'evidence-based' is too narrowly defined, then this could stifle innovation and place too much onus on chiropractors to be abreast of a huge amount of knowledge which was felt to be unrealistic [i.e. at D7 provide evidence-based options provided by other healthcare professionals]. The inclusion of

'expected natural history' was also queried and felt to be problematic by some, including a Professional Association and Educationalist.

Members of another Professional Association raised questions regarding what the GCC would consider an appropriate 'care plan' and it was commented that B6 seems the best opportunity to provide greater clarity.

The requirement to tell the patient if proposed care is not supported by evidence of accepted quality [D6] was also queried, particularly as it was felt that not all patients want all the information about their treatment. The definition of 'accepted' quality was also questioned.

> So I think just based on what you were saying there, what you are expected to say is, "Right, I'm going to do this test now but there is no real evidence to support the outcomes of it." I mean how is that going to pan out in a PCC hearing?
>
> Individual involved in FTP proceedings (at event)

The use of evidence-based outcome measures was flagged as problematic by a number of survey respondents, who tended to see it as an example of the lack of understanding of chiropractic care and unworkable on the ground. Some saw it as a 'gold standard' and aspirational. An Educationalist called for clear guidance and a clear justification for its introduction:

> Given the potential for a significant increase in workload for clinics, it must be justified by an explanation of what problem such a requirement is solving and evidence that outcome measures solve this problem. There must be a clear definition of what outcome measures are permissible and what are not.
>
> Survey response from Educationalist

The RCC welcomed the introduction but felt that 'evidence-based outcomes measures' should read 'validated measures'. It was agreed that this is an important area to consider, that it needs further thought and that chiropractors need clear guidance. Any requirements need to bear in mind the fact that some practitioners will be working on their own in very small businesses. Similar points were also made at the Expert Witness session, particularly as it mentions this should be done 'before commencing care'.

> You could argue that in the Code it should be just a very basic standard, you must measure outcomes objectively. Something simple like that. And then the guidance would expand on best practise in terms of measuring outcomes. To me in the glossary, outcome measure, it reads a bit more like best practise rather than a basic expectation
>
> RCC event

> I think it was the 'agree and document evidence-based outcome measures' that was maybe pushing at a gold standard rather than a standard of a reasonable chiropractor.
>
> Individual involved in FTP proceedings (at event)

D9 specifies '*continuously monitor (and record) the patient's progress…carry out formal reviews at regular intervals*'. It was noted at the Expert Witness session that a formal review is something that is clinically indicated rather than something which should be done by at specified times. It was also flagged that there should be a requirement in the guidance to benchmark against a patient's initial presentation as part of the review.

The introduction to Principle D states that chiropractors are '*expected, as health and care professionals, to engage in interventions that support prevention and health promotion to the benefit of individuals and the population'*. It was queried at the Expert Witness session as to whether this was a reasonable expectation and whether a chiropractor could be sanctioned for not doing this. Similarly, some survey responses, including two Professional Associations, queried the reference at D13 to support public health initiatives, particularly if they are not in line with their beliefs or value system (the example given of Covid-19 vaccinations). However, these additions were welcomed by the RCC and two Healthcare Regulators.

> The RCC welcomes this new Standard which requires engagement with prevention and health promotion interventions and public health initiatives while considering health inequalities.
>
> Survey response from RCC

> In the area of health promotion such as smoking cessation, exercise, dietary advice, etc chiropractors are well placed to discuss this with their patients. However, where the interpretation of this standard provides substantial concern is if we are being encouraged to support public health initiatives that exceed our knowledge. This standard suggests that we would be instructed to do so blindly, even if we may disagree with it on an individual professional, moral, ethical level.
>
> Survey response from Professional Association

The wording of D15 was felt to be ambiguous by some survey respondents. The definition of 'research in practice' at D15 was queried at the Educationalist session. The RCC session suggested that this could be amended to '*when engaging in research, do so ethically and effectively. This may include promoting'*.

Use of technology

It was queried at a number of sessions and by some survey respondents whether there was an absolute requirement for chiropractors to use digital technologies to enhance practice (Introduction to Principle D and D14) or if this was an aspiration. It was felt that this shouldn't be compulsory given the training implications and also that the use of technology isn't always in the best interest of the patient i.e. where risks outweigh the benefits or where used to justify the use of practice-building instruments (e.g. neuraltherm scanners) to enhance practice income. It was suggested that the word 'consider' replaces the requirement to 'use'.

As well as welcoming the change to D4 which now refers explicitly to the use of diagnostic imaging, a Healthcare Regulator also highlighted the need for registrants to consider risks and benefits of using technology.

It was noted that the use of the term 'digital' is ambiguous as to whether, in the context of chiropractic, it means electronic or using the fingers.

The use of the word 'effective' was also challenged – with the suggestion that this should be changed to 'appropriate' as chiropractors can't always guarantee effective care.

There was some discussion about the need to future proof the Code, with the absence of any mention of AI highlighted. It was queried whether there should be specific mention of AI or whether separate guidance was sufficient.

> I was going to suggest was that that maybe the wording needs to reflect the chiropractors' responsibility that as you said, they're not just devolving to AI to do things, they're still responsible for it.
>
> Educationalist event

4.6 Principle E – Establish and maintain clear professional boundaries

The Principle was specifically welcomed by two Professional Associations and Healthcare Regulator.

> [Named Healthcare Regulator] welcomes the updates to these standards and especially the broadened definition of 'relationships' to include interactions with carers.
>
> Healthcare Regulator

Another Professional Association asked for consideration that not all chiropractors work in clinics and some treat sports teams etc. so the Standards need to take this into account.

A number of survey respondents were unclear about the meaning of emotional and financial boundaries and a Professional Association requested further clarification of

the latter. The latter also noted that power imbalances are shifting because of the amount of information available online and other influences.

The inclusion of '*If there is a clinical need for an item of clothing to be adjusted, obtain informed consent from the patient'* at E3 was discussed during the Educationalist session and flagged by a number of survey respondents. It was asked what is the threshold for getting consent (does it depend on what the item of clothing is and how much it is adjusted) and does it need to be recorded?

Use of chaperones

In relation to the guidance in the Code about the use of chaperones, there was some call for the GCC not to be too prescriptive about the requirements in relation to those chiropractors who practice on their own because it may create logistical issues. It was queried whether there is evidence that there are a higher number of complaints in relation to sole workers.

It was also pointed out that it can be difficult for chiropractors to predict when a chaperone may be required in advance of a consultation and that the need for a chaperone during 'intimate examinations' (E4) creates uncertainty as 'intimate' can mean different things to different people.

However, there was some discussion at the Expert Witness session that 'you must, where possible' was not acceptable and that the patient must always be given the option. It was felt that the patient could be offered to come back at another time if the chaperone was not available on that day or for them to be referred to an alternative practitioner. It was noted that the wording around ceasing treatment may need to be reviewed to allow for the latter possibility.

> It says wherever possible offer a chaperone. Does that mean a chiropractor working by themselves without a receptionist who wants to do an intimate examination on a female patient, that isn't possible, so that's fine, just go ahead and do it? I don't think that can be right.
>
> Individual involved in FTP proceedings (at event)

Further advice was requested in relation to best practice about who the chaperone should be i.e. someone linked to the patient or someone independent. In this instance, the chaperone was seen as a means of protecting chiropractors as well as patients (and so the decision whether to have a chaperone is not solely about patient preference).

> I think we agree the need for a chaperone in certain situations, but as sole traders who would you recommend as a chaperone who is a third party (i.e. not a family member or friend of the patient) in order to protect the chiropractor too?
>
> Professional Association event

It was suggested by a Professional Association that instead there is reference to notifying a patient when they book that they may be receiving hands-on treatment in a one-to-one setting so they are welcome to bring a chaperone (as per practice in other health care settings).

4.7 Principle F – Obtain appropriate, informed consent from patients

There were relatively few comments on this Principle in response to the survey or discussions.

It was highlighted that the guidance should be clear about when it is appropriate to ensure informed consent i.e. at which point in the patient journey. Further clarification about GCC requirements in terms of evidencing informed consent was requested at a Professional Association session, particularly whether it is required to get a signature from the patient at every visit. It was felt to be overly burdensome and creating patient dissatisfaction. This was also queried by a survey respondent:

> Clarity on when written or verbal consents are more appropriate. If a patient returns with the same or very similar complaint is implied consent ever acceptable. More detail is needed here in my opinion.
>
> Survey response from Individual Chiropractor

A Professional Association also requested that the GCC consider inclusions regarding AI, digital consent and the use of digital transcribes in addition to 'records'. This would help registrants and would allow for innovation.

It was also asked at a number of sessions if 'informed consent' is the right terminology throughout or if it should be 'valid' consent (as the latter incorporates informed consent, plus other factors such as capacity and its voluntary nature). This was also mentioned by the RCC in its survey response.

One survey respondent queried whether F1 implied the provision of information in foreign languages was expected.

4.8 Principle G – Communicate professionally, properly and effectively

In the survey, there were a few mentions of perceived repetition in places, particularly with Principle F. Some respondents also felt that elements of the Principle were aspirational in nature, for example expecting the registrant to 'use language that promotes patients' health literacy'.

A number of survey respondents queried what 'reasonable steps' to understand and meet the language and communication needs and preferences of the patient [G1] actually meant. A Professional Association felt that the patient could take on more responsibility for their needs in this respect.

There were a few comments about replacing the reference to complaints in G3 with feedback or expressing concerns. It was requested that there is some reference to

frequency in G4 'Communicate effectively with other professionals' (linked back to communication with GPs).

The requirement at G5 to provide information to patients about *everyone* who gives care was read as being providing information on a range of health colleagues working outside the immediate practice and, therefore, too onerous. There was evident confusion about what expectations were in this respect from survey respondents and in discussions.

There was some call for the Code to include guidance relating to clinics making it clear to patients who they are being treated by i.e. if they are seeing osteomyologists or chiropractic assistants (CAs) rather than chiropractors.

> Using the term chiropractic is incredibly misleading when referring to CAs. You regulate it with regards businesses? Why not with CAs?
>
> Professional Association event

The use of the term 'chiropractic assistant' was also flagged as problematic with a Professional Association requesting more stringent guidance on its use.

Two Healthcare Regulators particularly welcomed the inclusion of social media [G6] as did RCC, with the caveat that the latter assume that the Standard is not implying that registrants have to use the internet.

> The standards at G6 of the Code reflect our guidance in this area [around social media use] and recognise that providing guidance around expectations in this area is an important step in maintaining public trust.
>
> Healthcare Regulator

> The [named Healthcare Regulator] welcomes the amendments to these standards and believes the inclusion of specific standards relating to social media will be especially helpful to registrants and service users.
>
> Healthcare Regulator

A Professional Association requested that '*responsibility for online information, including social media'* should also include personal and professional profiles/ accounts.

There were a number of questions at the events and in survey responses from individual chiropractors relating to expectations of chiropractors' behaviour on social media, particularly whether they are able to express certain opinions, be members of specific groups and like/follow various pages and individuals. This was particularly in relation to the duty to promote public health. A specific question was about whether the chiropractor could be a member of a prayer group/church and whether this would be seen as an issue in relation to inclusivity and diversity.

> I am concerned this Standard may infringe on clinical or academic autonomy and free speech. For example chiropractors and associations promote common messages on manual handing/ posture Principles that are not supported by the current literature or public health initiatives, would these be acceptable?
>
> Survey response from Individual Chiropractor

There was also concern from a Professional Association that this requirement does not impinge upon discussion on closed forums and a call for a collaborative approach to drawing up supplementary guidance in this area.

A survey respondent queried clarification about the responsibility of chiropractors when using a third party for communication or marketing.

4.9 Principle H – Foster collaborative healthcare, effective professional relationships and safe, supportive workplace practice

Principle H is a new addition to the Code and, as such, there were a relatively large number of associated comments.

A Healthcare Regulator commented positively about a number of Standards in Principle H in particular:

> The standards at H3 – to foster effective team working - combined with the standard at H4 - to demonstrate leadership - and the standards at H5 - to treat others in the workplace fairly and with respect, are good indicators of the expectations of professional responsibilities towards colleagues.
>
> The bystander requirements in standards H5 and H6 - which create a duty to act when the performance or conduct of colleagues puts others at risk of harm - reflect the new duty created in [own Standards] to take *action* in response to bullying, harassment, discrimination.
>
> We note the standards at H7 regarding contributing to mentoring, teaching and training and the importance of recognising this area of development.
>
> Healthcare Regulator

However, it was highlighted by others that there is some duplication and that the content is adequately covered in other Principles. There was also some strength of feeling that the Standards within this Principle represent an 'overreach' by the GCC and that they are aspirational in nature rather than representing minimum standards. For example, the RCC welcomed the new requirement to collaborate effectively with other health and care professionals, but suggested that it is clarified that collaboration should take place *'where appropriate'*.

Some of the expectations around, for example, teaching and leadership were felt to be voluntary rather than mandatory. There was some confusion about how the Standards relate to established employment law and HR issues.

> There are too many sections here that read like a list of ideals rather than identifiable minimum standards of conduct a chiropractor should be held to.
>
> Survey response from Individual Chiropractor

> Whilst I agree with the aim of creating a safe and supportive environment for all, from the aspect of the regulator I see the boundary to lay at the impact on a patient or patient care only. Amongst work colleagues I would expect this to fall under employment law.
>
> Survey response from Individual Chiropractor

> The Code addresses chiropractors and the manner they relate to staff and employees. Is this not a matter for employment tribunals? This is not related to patients. Creates confusion over who is dealing with it.
>
> Professional Association event

There were a number of responses to the survey from individual chiropractors which requested more emphasis on respecting fellow chiropractors.

> I feel that this Principle is missing something about respect and not 'bad-mouthing' other members of the profession as it looks unprofessional and is stunting the growth of the profession as a whole.
>
> Survey response from Individual Chiropractor

Working with and responsibility for colleagues

The RCC welcomed the inclusion of H7 '*allow your workplace colleagues to meet their regulatory duties'*. They suggested that requirements could be broadened to include training and professional development responsibilities.

> The RCC welcomes this new Standard. We suggest that, in addition to allowing colleagues to meet their regulatory duties (responsibilities?), registrants are also required to allow colleagues to satisfy their training and professional development responsibilities.
>
> Survey response from RCC

However, others queried what exactly is meant by the Standard and were concerned about the implications for different workplace situations.

> For example, what would be the situation in the case where an employer hirers other chiropractors, what would allowing them to meet their regulatory duties look like? And to what extent would be the expectation under the Code?
>
> Professional Association event

An example was given in response to this question of a colleague being unable to meet CPD requirements because of workload and the expectations of the

chiropractor in this scenario. Again, further elucidation of what the requirements were was requested.

> But what if the situation arises that you are unaware that that situation has happened, until such time as that person is unable to complete their CPD? Some practices have many practitioners. Does it then become the responsibility of the other registrant to monitor whether that person is fulfilling their regulatory duties? And, again, my question behind the question is how is that protecting the patient specifically?
>
> Professional Association event

Similar questions were raised in relation to C2 '*Ensure that you, and anyone that has a chiropractic qualification and works with you, is registered'.* It was asked whether this was an individual chiropractor's responsibility or that of the employer. In a previous version of the Code, this was under 'Practice arrangements' section and clearly the employer's responsibility.

> So we're now in a place that, you know, I now have a regulatory responsibility for people who are in my practice, even if I work with them, but they don't work for me.
>
> Educationalist event

At a number of discussions and in survey responses the meaning and intention behind this Standard was queried as it generated some confusion and debate. It was queried if it meant colleagues need to be registered with a regulator even if they are not a chiropractor.

It was queried what exactly the expectations are in relation to H2 '*Delegate tasks or duties only if safe and appropriate to do so'.* A Professional Association expressed concern about delegation to less qualified persons (such as Chiropractic Assistants or similar). Another Professional Association requested clarification about whether this is just within the chiropractic practice and how a registrant would be expected to demonstrate that a person they delegate to is qualified, competent, supervised and supported. They also queried if individual qualified and competent, why they would need to be supervised and supported.

Also, relating to C2, it was asked if being clear with the patient that you are registered means verbal notification or something written.

Reporting others

The expectations outlined in H5 and H6 were broadly welcomed by Healthcare Regulators and RCC.

> The bystander requirements in standards H5 and H6 - which create a duty to act when the performance or conduct of colleagues puts others at risk of harm

> - reflect the new duty created in [named own Standards] to take action in response to bullying, harassment, discrimination.
>
> Healthcare Regulator

However, the duty to act on the '*poor behaviour of others'* in the introduction to Principle H was felt to be challenging by some, particularly in the context of chiropractic care settings where there may be commercial interests at stake. It was flagged that it states 'others' rather than 'chiropractors'.

There was concern at a number of sessions about an increased number of complaints about chiropractors from other practices, 'turf wars' and some debate over how to balance protecting the public versus facilitating spurious concerns. There was a particular issue with Principles C and H in this respect.

> This requirement [H6] could open the floodgates to a whole slew of vexatious complaints. While whistleblowing should be condoned, it is far from certain whether the education of chiropractors in the UK ensures familiarities with the duties, responsibilities and consequences of submitting such concerns. Is there scope for local resolution or is the intent to report all such concerns to the appropriate regulatory body? If the latter, this could create an unsustainable burden on the GCC.
>
> Individual involved in FTP proceedings (at event)

It was suggested that the Code should include a statement similar to what has been included previously about '*you must not unjustly criticise another healthcare professional*'.

> That sort of safety net to that has been taken away and I think something like that needs to be there to counterbalance, if you like, the whistleblowing requirement.
>
> Individual involved in FTP proceedings (at event)

Other issues in relation to H5, H6 and C12 were raised including:

- A request for clearer guidance on what it means to take action/report colleagues.

> It's H5 where it says about taking action. And again, it's like well with who and where? I think the same with H6. So just a bit more clarity on how? Escalate or report and it's like what do you mean, to a colleague?
>
> Professional Association event

- Is a duty to report others, i.e. professionals speaking about other professionals, classed as a complaint to be investigated?
- Is there a mechanism that the GCC could create where you could whistleblow but it wouldn't necessarily trigger a formal complaint?

- At C12 does 'colleagues' mean other chiropractors? Does it mean raise concerns to the regulator, the individual themselves or the Practice Manager?
- Is C12/C14 necessary given content of C1?

Collaboration with other professions

It was commented that requirements in relation to collaboration should not be mandatory. For example, in the introduction to Principle H '*Chiropractors are also required to give professional support to others, where appropriate'*. It was queried who 'others' refers to and what it means by support. A general point was made about expectations in this area for chiropractors working in different settings and whether some of the Standards are not feasible to achieve.

> I think it [Principle H] just requires a bit more thought. I think the concepts of it are good but I read that and thought well, that's great if you're working in a chiropractic college. But outside of that, if you are working independently on your own and the bar is set as we expect you to do this, is it really a failing if they don't want to teach, train and be with their colleagues? If they go, "I don't want a student in the room with me" is that really a failing of them as a professional?
>
> Professional Association event

There was some discussion about H1 '*Enhance the integrated care of the patient by collaborating effectively with other health and care professionals*'. This was felt to be difficult given that not all chiropractors work in multi-disciplinary settings. Some also referenced a perceived reluctance of other professionals to engage with the chiropractic profession and their scepticism of chiropractic treatment (in front of patients).

> This can be extremely problematic when other healthcare professionals (often physios/ doctors) actively discourage chiropractic care.
>
> Survey response from Professional Association

This was described as a 'one-way street' and it was queried whether other professions have a similar Standard in their codes. It was asked why chiropractors must mention other professions when outlining treatment options to prospective patients, when other professionals (specifically GPs) do not have to mention chiropractors. It was suggested by RCC and a Professional Association that '*where appropriate'* could be added to this Standard.

> I think the question here is how can we be held to a standard of collaboration when there is a good chunk of the other people that don't want to collaborate with us?
>
> Professional Association event

> Happy to work with other HCPs but many don't want to work with chiropractors. Is this going to be put in other HCPs' code of conduct and enforced?
>
> Survey response from Individual Chiropractor

It was queried whether the GCC could be doing more to educate other healthcare professionals on the chiropractic profession.

The requirements outlined in H3 '*Foster effective team working and professional interpersonal relationships. When required, support the design, delivery, evaluation, and enhancement of healthcare services, and the integration of patient care within these services*' were also flagged. It was felt that this would not be relevant for many chiropractors working outside of the NHS and some may struggle to see how it applies to them. It was also highlighted those working within the NHS already have additional duties placed upon them through the NHS Constitution.

It was suggested at the RCC discussion that H7 should specify 'regulatory and professional' duties to encompass post registration training. In terms of H4 it was felt that it would be difficult to demonstrate leadership and the use of 'autonomous' in this context was queried.

4.10 Principle I – Maintain, develop and work within your professional knowledge and skills

There were few comments on this area at the discussions and events other than some specific wording points. One query was highlighted at the Expert Witness session as to whether the wording of I4 meant that 'incompetent' educators may be subject to GCC sanction. If this is the case, it was felt to be a new development. Also, it was flagged at the Educationalist and RCC sessions that I7 was felt to be a bit ambiguous.

There were also relatively few survey responses in relation to this Principle. Several survey responses noted that the introduction refers to 'scope of practice' when this is not defined for chiropractors in the Act or Code. They also felt that many of these Standards are more aspirational rather than minimum expectations. This was particularly in relation to I1, I2 and I3.

> This Standard also feels aspirational and appears to be an attempt to bring more of the educational Standards into the code. We again feel this is addressed in other areas of the Code and cannot see how it would be assessable as a standard.
>
> Survey response from Professional Association

A Healthcare Regulator and RCC were broadly positive about the contents of this Principle and particularly welcomed the addition of reflective practice. Two Professional Associations were positive about I5 and I6 in particular.

> The Standards at I1 and I3, which seek to improve patient care through reflective practice and maintaining skills and knowledge to keep up to date with developments affecting professional practice, are also examples of a patient-centred approach in line with putting the interests of patients first.
>
> Survey response from Healthcare Regulator

Several survey responses suggested that requirements in relation to I7 '*Do not allow another person to take on responsibility for the clinical assessment or care of a patient'* should be clarified.

4.11 Principle J – Maintain and protect patient information

There were only a small number of comments in relation to the Principle.

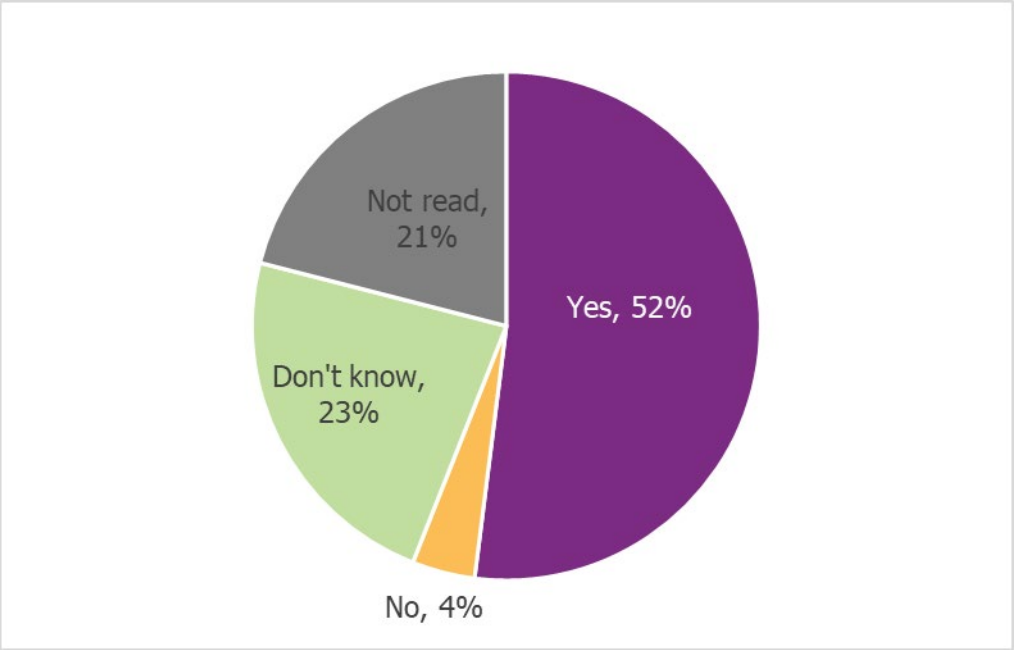
At the RCC session it was noted that the points in relation to the contents of patient records [J3] is crucially important, especially in terms of Fitness to Practise processes. Consideration could be given to adding additional elements that used to be in previous version of the Code [Principal H], including the records you keep must be accurate, reflect the clinical encounter, cover all interactions and must include other factors relevant to the patient's ongoing care including their general health. Clarification of what is meant by 'retrospective' was requested.

Specific requirements in relation to being responsible for data security [J1 & J6] were challenged, particularly as within some settings (NHS and other) there will be named individuals who are data controllers and have responsibility for the practice/department/organisation. It was mooted whether it is also preferable to employ a third party who has more expertise in data security and if Information Commissioner's Office (ICO) Standards are sufficient (rather than GCC in addition). A Professional Association requested some clarification where cloud-based services for storing data are used.

4.12 Equality, diversity and inclusion

The majority of respondents who were able to give an opinion felt that the Equality Impact Assessment accurately describes how the Code could impact on those with protected characteristics.

Figure 2 - Do you think that the Equality Impact Assessment accurately describes how the proposed Code of Professional Practice could impact any individuals or groups with one or more of the protected characteristics defined in the Equality Act 2010



Base: 119 respondents

The RCC welcomed the new Standard [C11] which they felt that, along with Standard C12, helps to uphold the principles of EDI. Some attendees are the Educationalist event were also positive about the inclusion of EDI.

It was mooted by others that perhaps more could be done to ensure that chiropractors see issues of equality, diversity and inclusion as something that they need to actively consider; as well as underlining the difference between equality and equity.

> Could anything be done to strengthen it in terms of making it a positive duty [to take action]…So whether it's something could be done or something in the language to focus not just on the equality side of things, but the equitable side of things as well.
>
> Individual involved in FTP proceedings

This was echoed by the survey responses of two Healthcare Regulators which welcomed strengthened EDI requirements but felt there was perhaps further to go.

> Several of the GCC's Standards touch on these aspects (A7, B4, C11). There may be scope for further strengthening however, to encourage registrants to actively seek to tackle inequalities, and promote equality, diversity and inclusion.
>
> Survey response from Healthcare Regulator

> This Standard [C11] could benefit from more active wording which has been added to other new Standards. For instance 'take action to ensure' your personal biases...
>
> Survey response from Healthcare Regulator

Although it should be noted that there was some discussion about the inclusion of 'bias' throughout the Code:

> I think it is sufficient to talk about personal values and beliefs. I do not believe including biases here adds anything to the statement [C11] or expectation.
>
> Survey response from Educationalist

At the RCC session and in survey responses, including from two Professional Associations, it was also noted that the wording of B4 '*Recognise the importance of promoting accessible healthcare for all patients, and support this in your practice*' is open to misinterpretation – does this mean, support the recognition of it or support accessible healthcare? This point was also highlighted at the session with Expert Witnesses who felt legislation could be referenced. It was noted that accessibility could mean physical accessibility or affordability.

It was commented at the discussions that F1 on consent should explicitly reference 'capacity' and there should be specific mention (and definition) of 'protected characteristics'.

Language requirements

The expectations of chiropractors in providing translators and the associated costs was raised at a Professional Association event and by Expert Witnesses. It was felt that G1 could be seen as implying that chiropractors need to meet patients' language needs.

> How much do I have to provide in terms of language and translation? I cannot be reasonably expected to cater for any and all languages.
>
> Professional Association event

It was queried whether C3 should specify 'local' legislation to cover specific requirements in Wales and whether '*If you practise in Wales, you should consider also making your policies available in the Welsh language'* adequately covers requirements in this area i.e. is it just policies or should it refer to other forms of communication?

> Is it worth having a more generic statement around abiding by the laws of the land as relevant to the region that you're working in, cause otherwise you might end up sort of tying yourself up in knots.
>
> Educationalist event

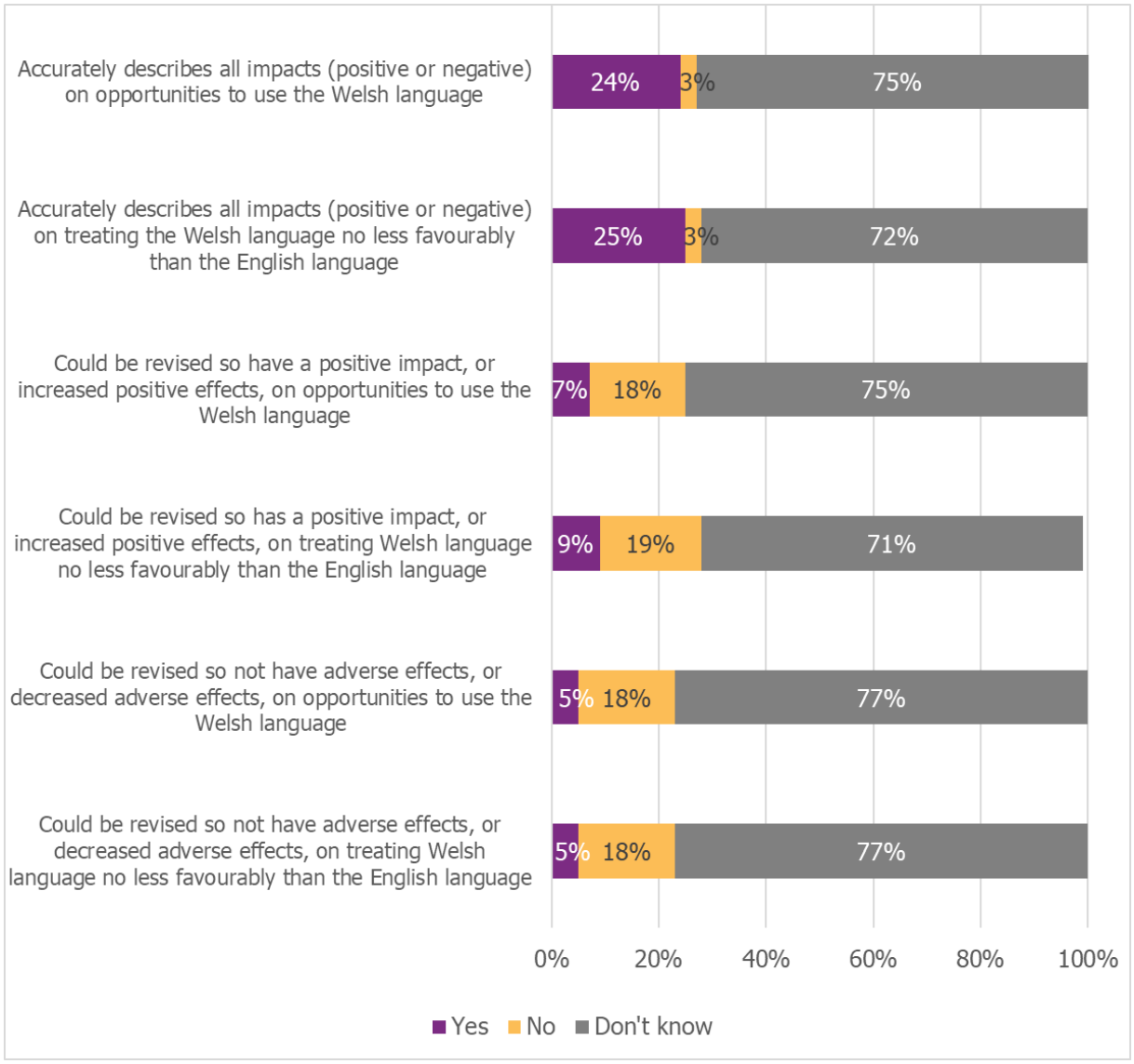
It was also flagged that the Code should also consider requirements in term of the Irish language in light of 2022 legislation[4] and possible future requirements (and possibly make reference to other languages too, for example Gaelic). The latter point was also made by a survey respondent.

Although there were high numbers of respondents who were unable to express an opinion, of the remainder, most were positive about the Equality Impact Assessment in relation to its treatment of the Welsh language.

There was a small amount of negativity from some individual respondents about the need for provision in respect of the Welsh language. An Educationalist welcomed the GCC treating the Welsh language equally in line with The Welsh Language Standards (No. 8) Regulations 2022 but highlighted that requiring registrants to consider it too, potentially imposes an expectation that documents should be provided in Welsh by them. They felt that this may go beyond the regulations imposed on businesses by the Welsh government and result in cost and administrative burden.

[4] Identity and Language Act 2022

Figure 3 - Views on the Equality Impact Assessment document in relation to the Welsh language

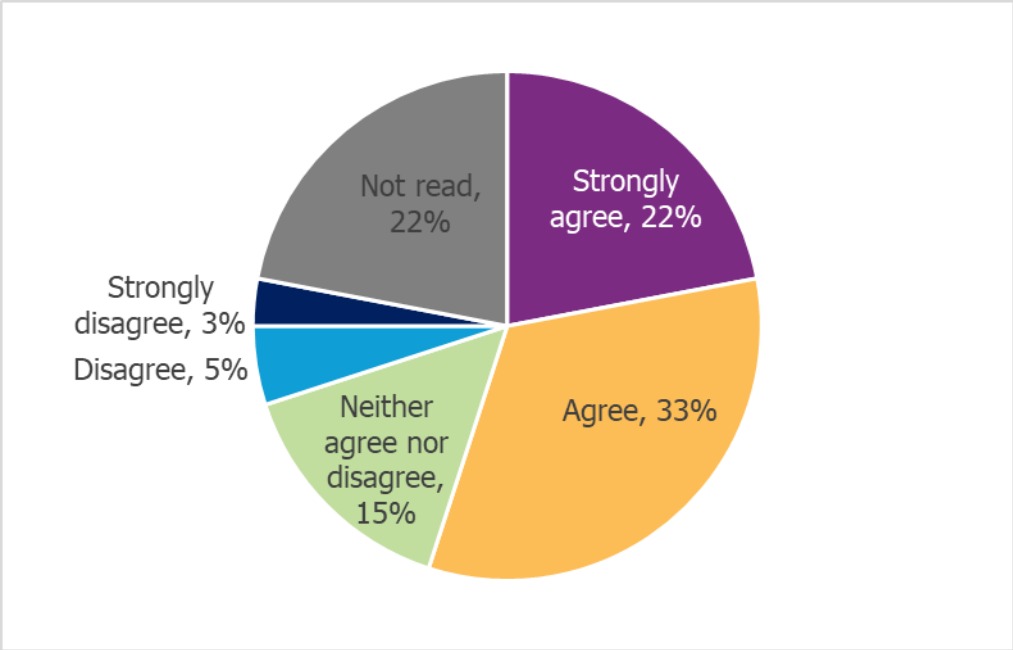


Base: 119 respondents

4.13 Comments on the glossary

In the survey, over half of respondents (55%) say that the definitions within the Glossary cover all of the terms that need to be defined, although a further 37% were neutral or had not read the document.

Figure 4 - To what extent do you agree or disagree that the definitions within The Glossary cover all the terms that need to be defined within the Code of Professional Practice document



Base: 119 respondents

15 respondents indicated that they felt that there were definitions missing, with 62 saying that there were not and a further 42 unsure.

Issues in relation to the definitions of 'evidence-based' and 'evidence-based practice' were raised – both in relation to the actual phrasing but also what the inclusion of it actually implies in relation to the GCC's view of practise.

> Quality of evidence as defined, suggests more rigid applications of evidence, but this does not sit well with the actual code provisions where there is flexibility with patient discussion, consent and also through giving notes where evidence may not be so helpful to make conclusions.
>
> Survey response from Individual Chiropractor

There were also a number of comments in relation to the absence of a definition of 'adjustment' and a perception that this was a result of the GCC's stance on chiropractic care.

> There is no definition of adjustment; imagine picking up the brochure of a car and it having no specifications about the engine.
>
> Survey response from Individual Chiropractor

A Healthcare Regulator indicated that it may be helpful to include a definition of 'apology' or 'apologising' which explains the aspects that a thorough apology should include and reiterate that it is not an admission of wrongdoing.

It was pointed out that the glossary should seek to explain relevant terms taken from the Code and not include explanations of terms that are not actually used in the Code. One respondent felt that some useful terminology from the 2016 glossary was missing.

Other specific comments on the glossary included:

- Should the definition of 'critical appraisal' including systematically examining facts and information as well are research?
- 'Plan of care' could be expanded to include aims and investigations, types of care, frequency and duration, when it will be reviewed.
- How will 'best interests of the patient' be defined?
- Review how explain 'rationale for care' and check how it is done by Health Education England
- What is meant by 'criminal convictions'
- 'Bias' needs further development with some concern expressed about the use of the word in the Code (although some Healthcare Regulators specifically welcomed additions in relation to this).
- Include a definition of 'valid consent'
- The term 'reasonable' is quite subjective and not covered in the glossary, which could be an issue throughout and something to consider against the level of clarity the Code of Professional Practice provides.
- The definition of 'intimate' may need to broadened to consider cultural differences, bringing out consent. In some cultures, it would be intimate to touch an ankle for example, or to expose the hair.

4.14 Gaps

Few survey respondents indicated that they felt that there are any Standards or minimum expectations of registrants that are missing from the draft Code. The highest numbers (6 and 7 respondents out of the 121 survey respondents) indicated that they thought there were gaps in Principles B and C respectively. Similarly, there were few identified gaps in the Code mentioned at the events and discussions. One specific comment was made about clarity around the role of guidance:

> The only other small comment I put was that it does talk about the role of GCC guidance but I think that could be strengthened. I think that's often misunderstood for chiropractors, for registrants, what is actually the legal status of guidance and I think that could probably be strengthened a bit.
>
> RCC event

The use of the shared values and link to patient feedback/engagement was welcomed but some felt that this could be more explicit. It was highlighted at several sessions and in the survey that the patient expectations section at the start of the current Code should be retained in some form (possibly before the summary table on the Principles and Values) as this is important in setting the tone that the Code is about patients and not the profession.

> Something that I think is missing is the first section of the current Code which is about patient expectations. I thought this was an incredibly positive shift that put patients first, and front and centre in the Code. It may be that this will be added later, but I don't know. And perhaps this is where plain English can be used more fully so that patients understand what is expected.
>
> Survey response from Educationalist

It was mooted that the patient has some responsibility themselves for their care i.e. in choosing the treatment, engaging and being clear about what they want – and that this could be better reflected in the Code. A Professional Association suggested this could be given greater weight throughout as patients' rights are so 'wholly enshrined' in the Code.

4.15 Name, order and flow

The renaming of the Code to the Code of Professional Practice was welcomed.

It was highlighted that the introductions to the Principles are inconsistent – some include descriptive text background, some are statements without requirements, some have expectations and some say 'must' and 'are expected to'. It was also felt to be odd to have these introductions which are aimed at a wider audience and then go directly into Standards which are aimed at chiropractors. It was felt to be unclear that all of the Principles are 'you must' statements.

A Healthcare Regulator commented that they felt that the 'multi-layering' of the concepts of Values, Principles and Standards could create confusion when interpreting the expectations of the Code.

In terms of the Code order, it was suggested that section J on maintaining and protecting patient information should come before section H on collaboration as this is more fundamental.

There was a call for careful consideration about what goes into the Code itself and what is more appropriately dealt with in toolkits etc. Some argue for more content in the guidance; others that more detail should all be in the Code as individuals are unlikely to search multiple documents.

4.16 Accessibility of the document

It was pointed out that the Code needs to be as accessible as possible for public, patients and registrants. A number of suggestions were made at the discussion sessions and events in this respect, including:

- Putting references in where a specific Principle relates to another Principle (it was noted that there is some unavoidable overlap/duplication but it can make it challenging to follow a thread of thought).
- Including a clear summary for patients and considering comprehension of specific language and jargon i.e. would patients understand the term 'patient-centred' or 'quality management Principles'.
- Grammatical issues/clarity of wording.
- Produce a video or animation outlining the key aspects of the Code.
- Consider different language needs.
- Ensuring that the Code can be searched in an interactive way once on the website (in a similar way to how other Healthcare Regulators present their Standards)
- Produce a summary of what the Code means for specific issues, i.e. payment plans, open plan treatment etc.
    - An example was given of the GMC taking a topic such as religious and personal beliefs and bringing together all of the relevant points from their Standards in one place.
- It was suggested that there needs to be a resource available for chiropractors that they can access up-to-date relevant legislation so that they can meet the requirements of C3.

A point about the use of simple terms rather than jargon was made by a survey respondent:

> Healthcare professionals know what 'person centred' conversations are. But I think it is bureaucratic language. I would much rather in plain English it said something like 'talking and listening to patients'.
>
> Survey response from Individual Chiropractor

4.17 Other issues

A number of other issues were raised or questioned including:

- The GCC registration fees were mentioned as being relatively high, particularly for new graduates and sole traders.
- It was asked how the GCC will be 'policing' adherence to the new Code.
- It was stressed that the GCC will need to ensure that the changes to the Code are consistently applied to the Guidelines.
- It was stressed that ideally the Code needs to be a live document with a built-in mechanism to allow for some evolution over time or to give scope to respond

quickly to specific issues, for example a future pandemic and/or specific Fitness to Practise cases, for example those relating to future use of AI.

- There were some positive comments about the engagement and consultation but also some suggestion that the draft Code could have been shared with Professional Associations in advance of the formal consultation.

5. Appendix

5.1 List of organisations who responded

British Chiropractic Association (BCA)

General Medical Council (GMC)

Health and Care Professions Association (HCPC)

General Osteopathic Council (GOsC)

McTimoney Chiropractic Association (MCA)

Professional Standards Authority (PSA)

Royal College of Chiropractors (RCC)

Scottish Chiropractic Association (SCA)

Society for Promoting Chiropractic Education (SPCE)

United Chiropractic Association (UCA)

5.2 Demographic breakdown of responses to the survey[5]

*Table 1 - Number of responses by stakeholder type**

Consultation response – stakeholder type	Number of responses
Registered chiropractor	78
Patient or member of the public	30
Membership body, company, organisation or charity	10
Work at an academic institute carrying out chiropractic education or research	2
Qualified chiropractor (but not registered)	1
Total	**121**

Table 2 - How long chiropractor has been registered

	Number of responses
Under 2 years	3
2 - 5 years	12
5 - 10 years	7
10 - 15 years	9
15 - 20 years	12
Over 20 years	34
Not specified	1
Total	**78**

Table 3 - Survey respondent demographics

	Number of responses
Country	
England	108
Scotland	4
Wales	1
Other	7
Gender	
Male	55
Female	52
Prefer not to say	12
Ethnicity	
White/White British	94
Asian or Asian British	4
Mixed ethnicity	1
Prefer not to say/other	20
Religion	
No religion/belief	43
Christian	42
Muslim	1
Hindu	1
Pagan/spiritual	3
Prefer not to say	29
Disability	
Yes	97
No	16
Prefer not to say	6
Sexual orientation	
Heterosexual	92
Gay man/woman/bi	5
Prefer not to say	22
Age	
20-24	2
25-29	9
30-34	8
35-39	7
40-44	6
45-49	9
50-45	14
55-59	12
60-64	14
65 or over	26
Prefer not to say	12

5.3 Response to Principles by stakeholder type

Table 4 - To what extent do you agree or disagree that the Standards reflect Principle A

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	45	24	-	4	2
Agree	29	6	1	4	-
Neither agree nor disagree	3	-	-	2	-
Disagree	1	-	-	-	-
Strongly disagree	-	-	-	-	-
Total	**78**	**30**	**1**	**10**	**2**

Table 5 - To what extent do you agree or disagree that the Standards reflect Principle B

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	36	24	-	3	2
Agree	29	5	1	3	-
Neither agree nor disagree	7	1	-	1	-
Disagree	6	-	-	2	-
Strongly disagree	-	-	-	1	-
Total	**78**	**30**	**1**	**10**	**2**

Table 6 - To what extent do you agree or disagree that the Standards reflect Principle C

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	34	25	-	3	2
Agree	29	4	-	3	-
Neither agree nor disagree	9	1	-	4	-
Disagree	5	-	1	-	-
Strongly disagree	1	-	-	-	-
Total	**78**	**30**	**1**	**10**	**2**

Table 7 - To what extent do you agree or disagree that the Standards reflect Principle D

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	31	26	-	2	2
Agree	29	3	-	2	-
Neither agree nor disagree	10	1	1	2	-

Disagree	6	-	-	4	-
Strongly disagree	2	-	-	-	-
Total	**78**	**30**	**1**	**10**	**2**

Table 8 - To what extent do you agree or disagree that the Standards reflect Principle E

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	41	26	-	5	2
Agree	28	3	1	3	-
Neither agree nor disagree	5	1	-	2	-
Disagree	4	-	-	-	-
Strongly disagree	-	-	-	-	-
Total	**78**	**30**	**1**	**10**	**2**

Table 9 - To what extent do you agree or disagree that the Standards reflect Principle F

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	37	23	-	5	2
Agree	34	6	-	3	-
Neither agree nor disagree	6	1	-	2	-
Disagree	1	-	1	-	-
Strongly disagree	-	-	-	-	-
Total	**78**	**30**	**1**	**10**	**2**

Table 10 - To what extent do you agree or disagree that the Standards reflect Principle G

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	33	25	-	3	1
Agree	34	4	1	5	1
Neither agree nor disagree	7	1	-	2	-
Disagree	4	-	-	-	-
Strongly disagree	-	-	-	-	-
Total	**78**	**30**	**1**	**10**	**2**

Table 11 - To what extent do you agree or disagree that the Standards reflect Principle H

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	27	25	-	3	2
Agree	33	4	-	3	-
Neither agree nor disagree	10	1	1	2	-
Disagree	5	-	-	2	-
Strongly disagree	3	-	-	-	-
Total	**78**	**30**	**1**	**10**	**2**

Table 12 - To what extent do you agree or disagree that the Standards reflect Principle I

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	32	25	-	3	2
Agree	30	4	1	3	-
Neither agree nor disagree	13	1		4	-
Disagree	3	-	-	-	-
Strongly disagree	-	-	-	-	-
Total	**78**	**30**	**1**	**10**	**2**

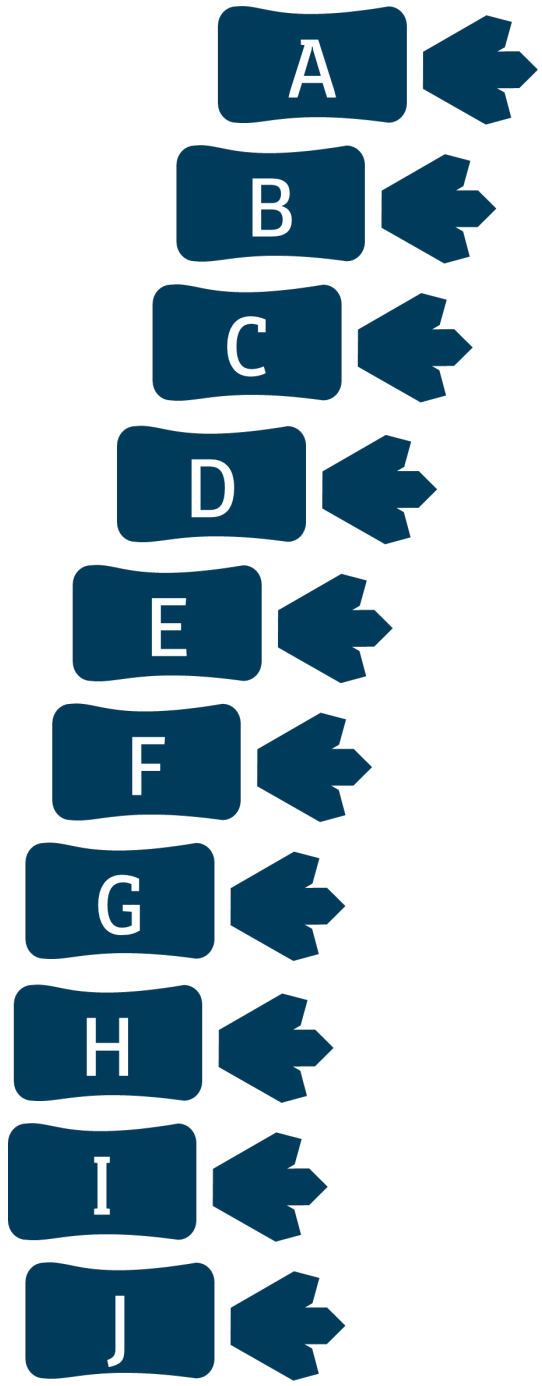
Table 13 - To what extent do you agree or disagree that the Standards reflect Principle J

	Chiropractor	Patient/public	Unregistered chiropractor	Organisation	Academic
Strongly agree	37	26	-	5	2
Agree	33	3	1	3	-
Neither agree nor disagree	8	1	-	2	-
Disagree	-	-	-	-	-
Strongly disagree	-	-	-	-	-
Total	**78**	**30**	**1**	**10**	**2**

Response to Consultation

The General Chiropractic Council's consultation into the Code of Professional Practice:

The process of consultation and outline of resulting changes.



General Chiropractic Council

1. Introduction

1.1. This document is published alongside the final Code of Professional Practice and an independent thematic review of the consultation. These documents illustrate the process of developing the Code of Professional Practice, the consultation process and the changes made to the proposed version as a result of the consultation.

1.2. The document should be read alongside the Code of Professional Practice and the independent thematic review.

1.3. The GCC Code of Professional Practice encompasses both a Standard of Proficiency and Standards of Conduct and Practice for chiropractors. The GCC last consulted on the Code in 2015, with the Code coming into effect in 2016. Since then, the profession has evolved in response to changing patient expectations, and developments in wider healthcare.

2. Developing the Code of Professional Practice

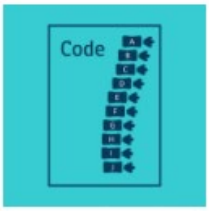
2.1. Timeline:

- **Autumn 2023. T**he GCC carried out the Code Scoping Review
- **December 2023.** Following the review, Council agreed to review the Code in 2024.
- **January 2024.** The scoping review was published and the intention to carry out a full review of the Code was announced publicly.
- **February 2024.** A survey of registrants identified the four values that underpinned their practice and were used to create a values based approach to the Code.
- **March 2024.** The values and Principles were agreed by Council.
- **April 2024.** The Code Conversation was launched. This used feedback to a blog, meetings with Council members and professional associations to inform three discussion events with the profession (held both online and in-person) throughout April and May.
- **June 2024.** Council considered and agreed to the proposals for the consultation and the Proposed Code of Professional Practice.
  The GCC also published two documents: **A summary of the Code Conversation** and **The independent report into the three registrant events** to illustrate how the Code Conversation had influenced thinking around the Code.
- **July 2024.** The Consultation went live on 22 July 2024.
- **September 2024.** The Consultation closed on 27 September 2024.
- **November 2024.** Thematic findings of the consultation discussed with Council.
- **December 2024.** The Code of Professional Practice, alongside this report and the independent thematic review of the consultation are considered by Council.

3. The Consultation

3.1. The GCC produced a number of documents and supporting documentation as part of the Code Consultation including:

- The Proposed Code of Professional Practice
- A Guide to the consultation
- The Equality Impact Assessment (including Welsh Language Impact Assessment)
- Glossary of terms within the Code of Professional Practice
- Mapping of the 2016 Code to the proposed Code of Professional Practice.



Proposed Code of Professional Practice


Consultation Guide


Equality Impact Assessment (including Welsh Language)

Glossary of Terms used

Mapping of 2016 Code to proposed Code

All of the documents were available online and a printable version was also produced.

3.2. The consultation was promoted in various ways, including:

- Emails sent to all stakeholders on the GCC's contact list, including those who responded to the Code Conversation.
- Emails were sent to all current registrants, and individuals applying for registration.
- Highlighting the consultation at existing meetings.
- Information on the main GCC website, including promotional material in the form of press releases, videos and social media posts to share.
- Encouraging chiropractors to ask their patients and colleagues to respond, and personalised letters were provided to them to assist with this.
- Encouraging education providers to ask their colleagues and students to respond, and personalised letters were provided to them to assist with this.
- Articles and information in the GCC newsletter.
- Information within the GCC email footer.

3.3. While respondents were encouraged to respond using the online questionnaire, they could also submit feedback by emailing or writing a freeform response, attending a consultation event or completing a hard copy feedback form.

3.4. The consultation materials and the online consultation questionnaire were made available in the Welsh Language.

3.5. Ten engagement events were held during the consultation period.

3.6. Seven discussion sessions with specific audiences were facilitated online by an external moderator, Gay Swait:

Date	Audience	Number of attendees
13/08/2024	Chair of Investigating Committee (IC)	1
15/08/2024	Education Providers	6
22/08/2024	Royal College of Chiropractors	3
11/09/2024	Chair of Professional Conduct Committee (PCC)	1
11/09/2024	Associations representing professional chiropractors (facilitated by GCC staff)	4
12/09/2024	Chiropractic expert witnesses	5
26/09/2024	Chiropractic expert witnesses – further session reconvened after first session for further discussion	4

3.7. Three evening consultation events for registrants were hosted by the Professional Associations. These were well attended online and took the form of a presentation from Nick Jones and Andrew Fielding, followed by a Q&A.

Date	Audience
25/07/2024	British Chiropractic Association
21/08/2024	UK Chiropractic Alliance (members of the MCA, SCA and UCA)
11/09/2024	UK Chiropractic Alliance (members of the MCA, SCA and UCA)

3.8. The online questionnaire ran from the 22 July until 27 September 2024.

3.9. The questionnaire comprised:

- Interest questions (to understand the respondent's relationship to the Code of Professional Practice)
- Three questions on each of the 10 Principles, with further opportunity to comment specifically on the Principle as a whole or on individual Standards
- Questions on the Glossary, and the Equality and Welsh Language Impact Assessment
- Demographic questions

- Two general questions at the end – on the consultation process, and on the Code of Professional Practice as a whole.

4. Responses to the Consultation

4.1. In total, 121 responses were received in response to the consultation:

Respondent self-reported description	Number of responses
Registered Chiropractors • Of which currently non-practising, or awaiting registration	79 3
Patient or member of the public • Of which have seen a chiropractor since January 2024	30 27
Work at an academic institute carrying out chiropractic education or research	2
Membership body, company, organisation, charity, regulator or governmental body	10

4.2. It should be noted that some individual chiropractors and representatives of stakeholder organisations attended discussion sessions or events, and also submitted a response to the survey. The professional association events were used by the professional associations to develop their responses.

4.3. The written responses comprised:

Submission route	Number of responses
Received via the online questionnaire	116
Received via freeform response	5

5. Analysis of the Consultation Response

5.1. It was important to consider the responses to the consultation both on an individual level (considering each suggested change on its own merits) and thematically (what were the themes emerging from the consultation as a whole).

5.2. Each comment received within the online questionnaire was manually categorised by the GCC:

i) Actionable Suggestion (a comment which suggested a change to a Standard or Principle)

ii) Positive (supportive of a Standard or Principle with no suggested change)

iii) Negative (opposed to a Standard or Principle with no suggested change)

iv) Neutral (comment too brief to be able to decide whether positive or negative)

5.3. Sentences within the freeform responses were assigned to Principles and Standards within the Code of Professional Practice, using the questionnaire as a guide, and then categorised in the same way.

5.4. In total there were 806 comments received across the 116 online questionnaire responses, and a further 219 relevant specific comments were extracted from the five freeform responses.

5.5. The GCC also searched the transcripts for quotes referencing specific Standards, and these quotes were extracted from the transcript and assigned to the Standard. A total of 320 relevant specific comments were extracted from the event transcripts. Where a quote referenced multiple Standards, it was assigned to multiple Standards.

6. The Thematic Review

6.1. The GCC commissioned Community Research, an independent research company, to consider the consultation responses and provide an independent report into the themes across the consultation.

6.2. To assist with writing their report Community Research were provided with:

i) Anonymised, but otherwise unprocessed, questionnaire data

ii) The free form text responses

iii) The categorised comments (with categories) from the questionnaire and the freeform text responses.

iv) Transcripts and, where available, recordings of the consultation events.

6.3. The independent report from Community Research identified 10 broad themes from the responses and is published separately.

6.4. The report was used to inform thinking around the Code of Professional Practice, and to highlight areas where further guidance from Council was required.

7. The Individual Principle and Standard Review

7.1. The GCC considered each Principle and Standard, alongside all the comments and quotes relevant to that Standard or Principle, and the findings of the thematic review. For each Standard the GCC considered if the Standard required any changes, and then the nature of any change.

7.2. The changes to individual Principles and Standards are set out in section 9.

8. Thematic Review Findings

8.1. The thematic review by Community Research identified 10 key themes across the consultation. These were:

- Positive Feedback
- Focus on Patient-centred care
- Minimum standards or aspirational approach
- Clarity over “must” and “should”
- Relationship to other healthcare standards
- Perceived narrowing of scope
- Legislative requirements
- Precision of language
- Use of the term “evidence based”
- Advertising and promotion.

Further information on these themes can be found in the Independent Report. Each of these themes is responded to below:

8.2. **Positive Feedback.**

We welcome the response to the consultation – both in terms of volume and quality of response. We welcome the feedback from respondents that they appreciate the values-based approach to the proposed Code of Professional Practice, and they recognise the amount of work put into the consultation.

8.3. **Focus on Patient-centred Care**.

We welcome the positive feedback from respondents to the importance of patient-centred care and person-centred care. We accept that there are a wide range of reasons for a person to seek chiropractic care, and in response we highlight that the definition of “patient” within the glossary is intended to cover all related terms that might be used such as client, customer or service user.

8.4. **Minimum standards or aspirational approach.**

We accept that there was some confusion as to whether the Code of Professional Practice represents a basic minimum Standard that chiropractors must adhere to. This was compounded by some of the publicity, the wording of one of the repeated questions in the consultation and some of the accompanying documents.

We also note that a high proportion of respondents agreed that the Standards within each Principle represent the “minimum Standards required to meet the Principle” suggesting that these were not aspirational.

This issue was discussed with Council and it was agreed that the Code of Professional Practice represents a **reasonable** expectation of chiropractors (which was the case for The Code (2016)). This is a higher level than a basic minimum Standard but is not aspirational.

During the review of the consultation each part of the Code of Professional Practice has been considered against a test of “reasonableness” and all references to “minimum” have been removed to ensure clarity.

Where a concern was raised in the comments that a specific Standard was aspirational, this has been carefully considered and a number of Standards have been reformulated as a result (details in 7.0 below).

We have moved a number of Standards from an action-based Standard to a knowledge-based Standard (“you must recognise…” or “you must understand”). This approach more closely reflects the Education Standards and lowers the expectation on the chiropractor.

8.5. **Clarity over “must” and “should”.**

We accept that the implied use of “must” (as opposed to an explicit “must”) impacted the clarity of the consultation document. In response all the Standards are now headed with the phrase: “As a chiropractor, you must:” and all Principles now begin with “You must”.

There was debate over whether to use “you should” within the Standards. As this suggests an aspiration, it was decided to be inappropriate, and so there is now only one use of “You should” within the Standards (referring to use of the Welsh Language in Standard G3).

Where some Standards were not absolute – and require a considered balance between the rights of the patient and other rights - they are now signalled by terms such as “you must consider” (E4) or “you must respect” (A4 and C8).

We acknowledge the comments that the Code of Professional Practice needs to be considered as a whole, particularly in relation to the overall burden on chiropractors and how the Code of Professional Practice will be used for Fitness to Practise allegations. In response, we have strengthened the explanation of the Fitness to Practise approach in the introduction, and highlight that an unintentional or minor breach of a Standard is unlikely to constitute unacceptable professional conduct:

“An unintentional or minor breach of a Standard is unlikely to constitute unacceptable professional conduct.”

The section headed “for patients” has been updated to encourage the patient to resolve complaints locally.

8.6. **Relationship to other healthcare standards.**

As a regulated healthcare profession (a member of a profession to which section 60(2) of the Health Act 1999 applies) it is right that chiropractors are held to a similar standard to that of registrants of the other healthcare regulators. In drafting the proposed Code of Professional Practice we sought

to pay due attention to the standards within the relevant codes of practice of other healthcare regulators, and apply them to chiropractic practice.

While we acknowledge the predominant “paid-for” model of chiropractic brings different challenges than practice within the NHS, we do not believe that this reduces the expectations of patients – if anything those are increased and there is a need for the Standards to highlight requirements which would be usual provision within the NHS.

We do not accept the suggestion that the Code of Professional Practice holds chiropractors to a higher level than other regulated professions – this does not consider the different legislation and models used by the other regulators (for instance the GMC Good Medical Practice document is able to specifically refer to guidance as part of their rules). In providing context to the Code of Professional Practice we recognise it will be important to make links with the codes of other professions.

We do, however, recognise some merit in the comments regarding the large number of Standards and Principles to adhere to. We have removed a number of Standards, which were felt to be duplicates, or were better combined. We have also removed some that were, on reflection, outside of the remit of the GCC (particularly within Principle J where the management of data is regulated by the Information Commissioners Office).

8.7. **Perceived narrowing of scope.**

The Code of Professional Practice has been drafted to apply to a much wider set of practice approaches than the previous 2016 Code – considering those working in education and research as well as a wide range of clinical roles. We welcome the feedback from the profession during the Code Conversation that helped us during the initial drafting stage.

We disagree that the Code of Professional Practice is intended to impose a narrower scope of practice onto the profession. This is not within the remit of the GCC, however we do highlight that each registrant must consider and understand their own individual scope of practice. The Code of Professional Practice has been updated to clarify this.

We disagree that the Code of Professional Practice prescribes how things are done. It is for each chiropractor, acting as an autonomous healthcare professional, to decide how to meet the requirements of each Standard.

We acknowledge there is a risk of an increase in complaints from registrants as the new obligations come into effect but will seek to mitigate this by setting expectations with guidance about when it is, and is not, appropriate to make a complaint about a colleague or fellow chiropractor.

We accept there was confusion about the use of the term “evidence”, and “evidence-based practice” and have worked to clarify these terms and ensure consistency (see 8.10 below).

8.8. **Legislative Requirements**.

We agree that there was a widespread misunderstanding of the scope of Standard C3 (now C4) concerning the responsibility to adhere to other regulations. Our intention was not to refer to other healthcare regulators, but instead sought to recognise that (because of the private healthcare business model), chiropractors were subject to regulation as a business as well as a professional. The Standard and glossary have both been updated to make it clearer that this refers to the Information Commissioners Office, the Advertising Standards Authority and other similar bodies.

We acknowledge there were concerns around the interaction of the Code with employment law (Principle H), and advertising and promotion regulation (Standards C3, C4 and C5). We have further elaborated on advertising and promotion below (8.11).

Principle H reflects the expectation of patients that healthcare professionals will encourage a positive working environment and allow all colleagues to concentrate on providing the best possible care. While this is a higher standard than that of employment legislation, it is also a reasonable standard considering the role and trust placed in the chiropractor as a professional. Principle H has also been clarified to consider more consistently who a chiropractor can reasonably be expected to have influence over.

8.9. **Precision of language**

We welcome the comments acknowledging efforts to ensure consistency of language, but accept that using consistent language and defining that appropriately is vital to the use of the document.

We have acted to distinguish and standardise terms, and use identical phrasing where we intend for an approach to be the same. These terms are then further defined in the glossary, to ensure consistency.

8.10. **Use of the term “evidence based”**

We agree that there was confusion within the proposal about the role of evidence within the Code of Professional Practice, with different terms used interchangeably. We acknowledge there is a lack of breadth and depth in chiropractic evidence in some areas due to the relatively young age of the profession, however we disagree that using “evidence informed” in place of “evidence-based” would help with the clarity of the expectation.

In response we have endeavoured to standardise and more clearly define aspects of evidence within the Code of Professional Practice.

Where appropriate, “evidence-based-practice” is used as a direct equivalent with “evidence-based medicine” as defined by Sackett et al. This definition is only used where specifically related to the provision of care and requires the

practitioner to combine published evidence with personal experience and patient preference.

Where the Standard defines evidence for a specific technique or action, (for instance when prioritising diagnostic tests) it is confusing to refer to “evidence-based” so the term “best quality of evidence that is available at the time” is used consistently. The definition of this term within the glossary recognises that the evidence base is constantly developing, and there is a range of quality of evidence.

8.11. **Advertising and promotion**

Although we acknowledge the clarity that Standard B3 in the 2016 Code gave to registrants about advertising and promotion, it was restrictive (by referring only to advertising it could be read to exclude other promotional activity such as online reviews) and dependent on the interpretation of a Standard set by another regulator.

The profession has demonstrated its ability to adhere to both the ASA standards and the GCC guidance on advertising, and the Code of Professional Practice does not seek to change the expectations regarding advertising and promotion.

The requirement to adhere to the ASA code is captured by Standard C4, and C5 and C6 reinforce the expectations of the previous guidance by bringing other promotional activity within the Code of Professional Practice itself. The guidance will be reviewed in light of new practices, but the expectations on the profession are expected to remain the same.

We acknowledge that the ASA code contains a stricter definition of evidence than is used elsewhere in the GCC Code of Professional Practice. This is entirely appropriate as, at the point of a prospective patient seeing an advertisement, the chiropractor is not able to apply their own experience or the preference of the patient to patients’ individual circumstances.

9. Response to the Individual Principle and Standard Review

9.1. Each Principle and Standard was considered individually alongside the thematic review and the comments specific to that particular Standard.

9.2. Where changes were made to a Standard they are set out in the tables below. It is important to note that some Standards have been re-numbered in the final Code of Professional Practice, and so the table contains both the reference in the final document, and the reference in the consulted document.

9.3. Definitions of change types in order of increasing level of change

	Definition of change
No change	The wording of the Standard is unchanged other than, in some cases, the addition of “You must” at the start of subsequent sentences within the Standard.
Text reordered for clarity	The meaning of the Standard is unchanged, but there may be changes in punctuation, sentence order or word order to aid clarity.
Re-worded for clarity following feedback	The meaning of the Standard is unchanged but, alongside changes in punctuation, sentence order or word order there may be synonyms introduced for consistency, or to aid clarity.
Content changes following feedback	There is a change of meaning, scope or approach within the Standard that means it has a different interpretation (often very slight) to the Standard originally proposed. Where this is the case, the change is described.
Standard removed	A consulted upon Standard has been removed. Where this is the case, the reason is explained.

9.4. The Standards that are considered to be Standards of Proficiency are marked with a tick in the column marked SOP.

9.5. **Principle A: You must put the interests of patients first**

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
A1	put the patient's needs and safety at the centre of their care.	A1	No change.	✓
A2	show respect, compassion and care for the patient. You must find out what matters to them and consider their needs and preferences. You must respond honestly and openly to their questions and must not pressure the patient to accept your advice.	A2	Content changes following feedback: *"Ask" replaced by "find out what matters" to reflect alternative approaches to conversation. "Any" pressure was removed to better reflect the need to persuade and influence patients.*	✓
A3	provide care based upon the principles of a person-centred approach by: i. engaging effectively with the patient through individualised conversations and interactions; ii. enabling and supporting the patient in their care, health and wellbeing; iii. involving the patient in decisions about their care; iv. collaboratively supporting and managing the patient when they have a high complexity of physical, psychological and social factors.	A3 A4 A5	Content changes following feedback: *This Standard amalgamates the consulted Standards of A3, A4 and A5 to better represent the principles of person-centred care and more closely reflect the Education Standards.* *Subsequent Standards have been renumbered.*	✓
A4	respect the patient's privacy, dignity and their right to choose who is present when their care is discussed and provided.	A6	Content changes following feedback: *The word "in the room" was replaced with "present" to account for provision in sports environments.* *The word "respect" highlights that the right is not absolute - the chiropractor must consider the needs and rights of the patient and balance it with the rights of the chiropractor to see a patient alone or in the presence of a chaperone.* *The addition of "and discussed" makes it clearer that this applies across the whole appointment.*	✓

A5	treat the patient fairly and without discrimination, interacting in a way that respects their choices, diversity and culture.	A7	Text reordered for clarity.	✓
A6	safeguard children and vulnerable adults by: • considering their safety and welfare; • assessing their vulnerability; • actively looking for signs of abuse. When you suspect a child or vulnerable adult could be at risk of, or suffering, abuse or neglect, you must promptly follow the established local safeguarding arrangements to report your concern. You must record your suspicions and actions.	A8	Text reordered for clarity.	✓

9.6. **Principle B: You must ensure safety and quality in clinical practice**

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
B1	protect patients by promoting and maintaining a culture of safety, seeking to prevent harm before it occurs.	B1	Re-worded for clarity following feedback.	✓
B2	act promptly and appropriately when you have concerns about the safety of a patient, and record what you did.	B2	Text reordered for clarity.	✓
B3	practise in a safe, hygienic environment where you actively identify and control risks. You must ensure all equipment you use is safe and meets relevant safety standards. You must plan for first aid and other emergencies.	B3	Content changes following feedback: *Changed “regulatory standards” to safety standards. Have added First aid, and removed the requirement to follow the procedures as this is self-evident.*	✓
B4	recognise safety incidents that risk the safety of a patient or another person, or have the potential to do so (“near miss”). You must understand the importance of reporting incidents through a suitable safety system, so that you, and the wider profession, can learn from them.	B5	Content changes following feedback: *The Standard has been changed from an action-based Standard ("report") to a knowledge-based Standard ("understand"). It has been reworded to define "near miss" within the text. It has been moved to be closer to similar Standards.*	✓
B5	recognise the importance of promoting accessible healthcare for all patients, and recognise how this can be supported in your practise.	B4	Content changes following feedback: *The Standard has been changed from an action-based Standard ("support") to a knowledge-based Standard ("recognise").*	✓
B6	collect, evaluate and use feedback and data about the quality of care of patients to continuously improve your practise.	B6	Re-worded for clarity following feedback.	✓

9.7. Principle C: You must act with honesty, and integrity, and maintain the highest standards of professional and personal conduct

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
C1	look after your health and wellbeing, seeking support when necessary. You must protect others from harm caused by the health, conduct or performance of you or any other regulated healthcare professional.	C1	Text reordered for clarity.	✓
C2	seek appropriate independent advice if you have significant concerns about your own fitness to practise, whether due to issues with health, character, behaviour, judgement or any other matter which may compromise the safety of patients or damage the reputation of your profession.	C14	Content changes following feedback: *"stop practising immediately" changed to "seek appropriate independent advice" to be more proportionate. The Standard moved to reflect similar themes with C1.*	
C3	have appropriate insurance and indemnity cover for the full scope of your own individual practice. You must be clear with the patient that you are registered with the General Chiropractic Council. You must be clear with the patient whether each person you employ, manage or lead that has a chiropractic qualification, is (or is not) registered with the GCC or another statutory UK health regulator.	C2	Content changes following feedback: *Clarification over the people in a workplace that a chiropractor can reasonably be expected to have influence over - "employ, manage or lead" defined in glossary.*	
C4	take responsibility, as an autonomous healthcare professional, for keeping up to date with, and following relevant legislation, regulations, codes of practice and GCC guidance.	C3	Re-worded for clarity following feedback.	✓
C5	when telling people about your services, ensure that all information is factual, verifiable, does not mislead, or exploit their vulnerability or lack of health knowledge. Where you delegate this, the accountability sits with you.	C4	Content changes following feedback: *Clarity that Chiropractor is accountable for all information about their service – even when this is delegated to another.*	✓

C6	ensure health information you share publicly is consistent with the best quality of evidence that is available at the time, and is credible and accessible to the intended audience.	C5	Re-worded for clarity following feedback.	✓
C7	ensure your behaviour is professional at all times, upholding and protecting the reputation of the profession and justifying public trust.	C6	Re-worded for clarity following feedback.	
C8	respect patient confidentiality, and dignity, at all times including online, during remote consultations, and when referring to patients anonymously.	C7	Content changes following feedback: *Changed "maintain" to "respect" to account for occasions where there may be a lawful basis to disclose information.*	✓
C9	be honest, fair, and transparent in your business. Your clinical judgement must not be prejudiced by any personal, financial or commercial interest. You must not ask for, accept, or offer, any inducement that may prejudice the care of a patient.	C8	Content changes following feedback: *"Detrimentally affect" replaced by "prejudice". "Recommendations and care" replaced by "clinical judgement".*	
C10	determine and share a clinical plan of care for the patient separately (and independently) from any financial payment plan. You must provide a clear contract for any financial payment plan which must include arrangements for refunds for unused care. You must not offer a financial payment plan that extends beyond the amount of care set out in your initial clinical plan of care for the patient. You must not pressure the patient to commit financially to long term treatment.	C9	Text reordered for clarity.	
C11	fulfil the duty of candour by being open and honest with the patient. Inform them if something goes wrong with their care which causes, or could cause, harm or distress. You must offer an apology, a suitable remedy or support, and an explanation of resulting actions.	C10	No change.	✓

C12	ensure your personal biases, values and beliefs do not prejudice the care that you provide to the patient, your personal interactions, or your professional reputation.	C11	Re-worded for clarity following feedback.	✓
C13	promote equality, diversity and inclusion, challenge discrimination and seek to tackle inequalities. You must raise concerns about colleagues if you believe they are treating people unfairly, have discriminated against someone or if their personal biases have prejudiced the care they provide. When raising concerns you must follow the relevant local procedures to maintain the safety of everyone involved.	C12	Content changes following feedback: *Further duty to promote equality added.* *“Detrimentally affect" replaced by "prejudice".* *“Prejudice” and “Relevant local procedures” defined within the glossary.*	✓
C14	have a reasonable justification for refusing or discontinuing care for a patient. You must record this. You must explain how they can find other healthcare professionals who could offer care, in a fair and unbiased way.	C13	Content changes following feedback: *"Do not unreasonably deny care" has been removed but a reasonable justification must be recorded. The duty to explain how to find other suitable care remains.*	✓
C15	promptly inform the GCC if, anywhere in the world: i. you are charged with a criminal offence; ii. you are convicted of a criminal offence; iii. you are the subject of a regulatory investigation; iv. you are suspended, dismissed, refused membership or placed under a practice restriction following concerns about your professional conduct or competence by another organisation (including regulator, insurer, professional body, employer).	C15	No change.	

C16	cooperate promptly and fully with any formal investigation, inquiry, or complaints procedure into your own professional conduct or performance, that of others or the care of a patient. You must respond to all reasonable requests from the GCC. If you are informed that you are the subject of a GCC investigation, you must follow any reasonable directions you are given by the GCC to assist in a fair and efficient process.	C16	Re-worded for clarity following feedback.	

9.8. **Principle D: You must provide a good standard of clinical care and professional practice**

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
Clinical assessment and diagnosis or rationale for care				
D1	take and record a thorough case history for the patient.	D1	Text reordered for clarity.	✓
D2	find out the patient's goals for their care. Before commencing care, you must establish planned health outcomes of the care, using recognised outcome measures. You must agree with the patient (and record) how progress towards the planned health outcomes will be measured.	D2	Re-worded for clarity following feedback.	✓
D3	with the valid consent of the patient, carry out an appropriate physical examination, prioritising methods supported by the best quality of evidence that is available at the time. You must explain to the patient (and record) the results of the examination.	D3	Content changes following feedback: *Physical examination now requires valid consent. "Using" replaced by "prioritising" to account for variable levels of evidence for techniques. Clarification of "best available evidence that is available at the time". Results of the examination need to be explained, not "fully" explained.*	✓
D4	ensure that you have the valid consent of the patient for any diagnostic investigation (including imaging) before it is carried out. You must carry out investigation in the health interests of the patient and in a way that minimises the risks to them. You must base the investigation on clinical reasoning, following authoritative evidence-based guidelines and adhering to all regulatory standards.	D4	Re-worded for clarity following feedback.	✓
D5	use the results of your clinical assessment of the patient to arrive at a working diagnosis or rationale for care which you must record and keep under review. You must keep the patient informed, including about any diagnostic uncertainty.	D5	Re-worded for clarity following feedback.	✓

Developing a plan of care				
D6	use the findings of the clinical assessment and the best quality of evidence that is available at the time, to propose (and record) a plan of care for the patient. You must tell the patient where your proposals are not supported by evidence of accepted quality and record your rationale and discussions.	D6	Content changes following feedback: *D6, D7 and D8 have been rewritten to separate the aspects of proposing care, patient understanding of the proposal and then agreeing the care.* *The patient's views is removed from the proposal of the plan of care - that will be taken into consideration once the plan of care is shared with the patient.*	✓
D7	inform the patient of the risks and benefits to the proposed plan of care. You must inform them of alternatives to the proposed plan of care including evidence-based options that may be provided by other healthcare professionals, and the expected natural history (prognosis without any care).	D7	Content changes following feedback: *D6, D7 and D8 have been rewritten to separate the aspects of proposing care, patient understanding of the proposal and then agreeing the care.* *This Standard was re-worded to clarify that the risks and benefits of the proposed care is a separate point of discussion to the alternatives to the proposed plan of care.*	✓
D8	apply evidence-based practice to develop, implement and record a personalised plan of care, in partnership with the patient. You must record and explain to the patient how progress towards the planned health outcomes of the care will be evaluated and set timescales. You must obtain and record the valid consent of the patient before implementing the plan of care. You must not propose a plan of care that is excessive or that is not justified by a robust, recorded clinical assessment.	D8	Content changes following feedback: *D6, D7 and D8 have been rewritten to separate the aspects of proposing care, patient understanding of the proposal and then agreeing the care.* *This Standard was rewritten to clarify the requirement for evidence-based practice.* *Reassessment was removed from this Standard as it was a repeat of D9.*	✓

Evaluating and modifying the plan of care				
D9	continuously monitor and record the patient's progress towards their planned health outcomes, evaluating and adapting the plan of care to meet their needs. You must carry out formal clinical reassessments at regular intervals, using recognised outcome measures to evaluate the effectiveness of care, as previously agreed with the patient and set out in their plan of care.	D9	Re-worded for clarity following feedback.	✓
D10	discuss with the patient their progression towards their planned health outcomes, agree any continuation or modification to their plan of care and record valid consent.	D10	Re-worded for clarity following feedback.	✓
Providing care				
D11	use evidence-based practice to select and implement safe, appropriate, care that meets the needs and preferences of the patient. This could include: • manual techniques; • rehabilitative interventions; • psychologically informed approaches; • education and advice. You must encourage and support patients to self-manage their health, signposting them to relevant resources.	D11	Content changes following feedback: *"This may include" was not meant as permission, but was interpreted as such. Changed to "this could include" to highlight examples only.* *"education and advice" is added.*	✓
D12	with the valid consent of the patient make, receive and implement effective referrals to other healthcare professionals, in the best interest of the patient.	D12	Text reordered for clarity.	✓

D13	engage in evidence-based interventions that support prevention and health promotion, considering health inequalities, for the benefit of the patient and population health.	D13	Content changes following feedback: *The Standard retains a duty to use health interventions to benefit patient and population health within daily practice.* *"Support public health initiatives" was removed following feedback that it could be interpreted to compel a chiropractor to promote initiatives outside their knowledge. The alternative reading ("support" as in "do not undermine") is adequately covered by C5 and C6.*	✓
D14	understand the risks and benefits to the patient before using any new technology and ensure that clinical care is safe and effective, whether it is provided face-to-face or remotely. You must obtain the valid consent of the patient.	D14	Re-worded for clarity following feedback.	✓
D15	ensure that in promoting or conducting research or using research in practice, you do so ethically and effectively.	D15	Re-worded for clarity following feedback.	✓

9.9. **Principle E: You must establish and maintain clear professional boundaries**

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
E1	recognise the power imbalances that come with being a healthcare professional. You must not abuse the position of power and trust which you occupy as a professional. You must not pursue or encourage improper financial, emotional or personal relationships. You must not cross any professional boundary: this includes sexual boundaries.	E1	Content changes following feedback: *The proposed Standard was widened to encompass all power imbalances – not only with patients. It also recognises that the imbalance may not be in the chiropractor's favour. This Principle will be subject to further guidance.*	✓
E2	ensure you, and any person you employ, manage or lead, treat all patients, their carers or others accompanying them, with respect and dignity.	E2	Content changes following feedback: *Clarification over the people in a workplace that a chiropractor can reasonably be expected to have influence over - "employ, manage or lead" defined in glossary.*	
E3	explain the reason to the patient and obtain and record valid consent if there is a clinical need for clothing to be removed. You must respect their right to privacy to undress and you must offer the use of a gown. You must always obtain a patient's consent if it becomes necessary during examination or treatment for an item of the patient's clothing to be adjusted.	E3	Re-worded for clarity following feedback.	✓
E4	consider the need for (or advisability of) another person to be present to act as a chaperone or advocate - for your own protection and that of the patient. You must, wherever possible, offer a chaperone if the clinical assessment or care might be considered intimate or where the patient is a child or a vulnerable adult, or where the patient requests one. You must record when you offer or use a chaperone or advocate.	E4	Re-worded for clarity following feedback.	✓

9.10. **Principle F: You must obtain appropriate, valid consent from patients**

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
F1	give the patient necessary, accurate, relevant and clear information in a format that is accessible to them so they can make informed decisions about their health needs and care options. You must take reasonable steps to check that they understand the information given to them.	F1	Content changes following feedback: *Addition of the word "necessary" to enable the information provided to support the concept of valid consent.*	✓
F2	give due regard to the capacity of the patient to give valid consent, considering that their capacity can change over time.	F2	Text reordered for clarity.	✓
F3	ensure the consent of the patient is voluntarily given, without pressure, or undue influence.	F4	No change. *However, the Standard has been moved so that Standards F1 to F3 reflect the necessary tenets of valid consent.*	✓
F4	obtain, and record, valid consent from a patient (or their valid authority) before: • commencing or amending assessment or care; • involving them in teaching or research; • making a recording of them; • disclosing identifiable information about them (unless there is another lawful basis to do so). Consent is a continuous process, and you must make ongoing checks that consent continues to be given.	F3	No Change	✓
F5	take particular care to obtain valid consent when seeing a child or vulnerable adult, considering if the patient is legally competent to give consent or requires the consent of a parent or valid authority.	F5	Re-worded for clarity following feedback.	✓

9.11. **Principle G: You must communicate professionally, properly, and effectively**

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
G1	take reasonable steps to understand and meet the language and communication needs and preferences of the patient, while maintaining their privacy.	G1	No change.	✓
G2	communicate clinical information to the patient clearly, sensitively and effectively. You must use language that enhances the care of the patient, promotes their health literacy, and supports shared decision-making.	G2	No change.	✓
G3	have visible and easy to understand information for the patient on fees, charging policies and how to make a complaint. This information must include the patient's right to change their mind about their care and their right to refer any unresolved complaints to the GCC. You must respond promptly and appropriately to any complaints that arise. If you practise in Wales, you should consider also making information available in the Welsh language.	G3	Text reordered for clarity.	✓
G4	communicate effectively with other professionals in the interest of meeting the patient's health and care needs and goals. You must only share information with the consent of the patient (unless there is another lawful basis to do so).	G4	Content changes following feedback: *The proposed Standard was updated to highlight there were other lawful basis for sharing information in the interest of meeting the patient's health and care needs (for instance if there is a concern for the safety of the patient).*	✓

G5	tell the patient who is responsible for their care. When arranging for another person to provide their care, you must be clear with the patient: • whether that person is registered with a statutory UK health regulator; • who holds accountability for that care.	G5	Content changes following feedback: *The Standard has been clarified to highlight the two relevant details to the patient when being offered delegated or referred care – whether the individual is registered with a statutory UK health regulator, and who is accountable for the care provided.*	
G6	when communicating online as a healthcare professional (including media sharing, social networking sites and user-generated content), do so responsibly. You must check that information is not misleading, and maintain professional boundaries and public confidence in the profession. Where you delegate this, the accountability sits with you.	G6	Re-worded for clarity following feedback.	✓

9.12. Principle H: You must foster collaborative healthcare, effective professional relationships and safe, supportive workplace practice

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
H1	collaborate appropriately and effectively with other health and care professionals, to enhance the integrated care of patients.	H1	Content changes following feedback: *"appropriately" added to allow for wider range of practice approaches.*	✓
H2	delegate tasks or duties only if safe and appropriate to do so. You must ensure that the person you delegate to is qualified, competent, and supervised and supported as necessary.	H2	No change.	✓
H3	demonstrate effective team working and professional interpersonal relationships as required by your role. This includes contributing to the design, delivery, and improvement of healthcare services.	H3	Re-worded for clarity following feedback.	✓
Your professional responsibility towards colleagues				
H4	demonstrate leadership appropriate to a healthcare professional and to your role.	H4	Re-worded for clarity following feedback.	✓
H5	treat others in the workplace fairly and with respect. You must report, follow-up and escalate concerns, following relevant procedures in your workplace, if you become aware of bullying, harassment, or intimidation. You must act quickly and appropriately where such concerns are raised to you, keeping everyone involved safe. You must encourage and support colleagues to raise their concerns.	H5	Content changes following feedback: *Reworded for consistent approach with H6 around reporting requirements, and clarity that this applies within a workplace.*	

H6	report, follow-up and escalate concerns, following relevant procedures in your workplace, where the performance or conduct of colleagues puts others at risk of harm. You must act quickly and appropriately where such concerns are raised to you. You must encourage and support colleagues to raise their concerns.	H6	Content changes following feedback: *Clarity that this applies within a workplace.*	
H7	be prepared, as necessary, to contribute to mentoring, teaching, training and professional development of students and other colleagues. You must allow any person you employ, manage or lead to meet their regulatory requirements.	H7	Content changes following feedback: *Added "as necessary". Clarification over the people in a workplace that a chiropractor can reasonably be expected to have influence over - "employ, manage or lead" defined in glossary.*	✓

9.13. **Principle I: You must maintain, develop and work within your professional knowledge and skills**

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
I1	engage in reflective practice, seeking feedback and analysing information about your practice and the care that you provide, in the interests of supporting continuous improvement.	I1	Re-worded for clarity following feedback.	✓
I2	regularly consider how to adapt or improve your practice considering new developments, technologies and evidence from research.	I2	No change.	✓
I3	routinely seek and critically appraise emerging evidence. You must integrate findings of the best quality evidence available at the time into your practice, to enhance the care of patients.	I3	No change.	✓
I4	maintain and develop your competence and performance, taking part in relevant and regular learning and professional development activities. You must be competent in all aspects of your professional work, including in any formal leadership, management, research or teaching role.	I4	No change.	✓
I5	recognise and work within the limits of your own knowledge, skills and competence. You must be clear with the patient about your limits.	I5	No change.	✓
I6	recognise the roles and expertise of other chiropractors and healthcare professionals. You must refer to them, or seek their expertise, when needed.	I6	No change.	✓
I7	not allow another person you employ, manage or lead to take on responsibility for the clinical assessment or care of a patient where it is beyond their level of knowledge, skills, or experience.	I7	Content changes following feedback: *Clarification over the people in a workplace that a chiropractor can reasonably be expected to have influence over - "employ, manage or lead" defined in glossary.*	

9.14. **Principle J: You must maintain and protect information about patients**

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
J1	adapt to advancing technology, including data sharing, media sharing and social media, to proactively protect the patient's personal information.	J1	Content changes following feedback: *The first two clauses of the proposed Standard are removed as they are covered by data protection legislation. The third sentence remains unchanged.*	✓
J2	be accountable for keeping patient records up to date, legible, and attributable. Your record must accurately represent each interaction with the patient. Retrospective amendments or additions to patient records must be identified clearly.	J3	Content changes following feedback: *"Accountable" added to reflect the ultimate responsibility for patient records rests with the chiropractor even if someone else (or AI) is writing on their behalf. Record must now "accurately" represent each interaction.*	✓
J3	store patient records safely, and securely (whether physically or digitally) so that they remain in good condition for an appropriate retention period (accounting for the age of the patient and when they were last seen).	J4	Content changes following feedback: *Following legal advice the appropriate retention period is not "described in law".*	
J4	have documented arrangements in place to protect or transfer patient records in case of moving clinic, ceasing practise or in the event of your death.	J5	Content changes following feedback: *The arrangements now need to be "documented".*	
J5	ensure that patient records remain your responsibility, even where a patient has moved, unless you have contractually transferred this responsibility to another healthcare professional or organisation.	J6	No change.	
		J2, J7	Standard removed. *These Standards were wholly covered by data protection legislation*	

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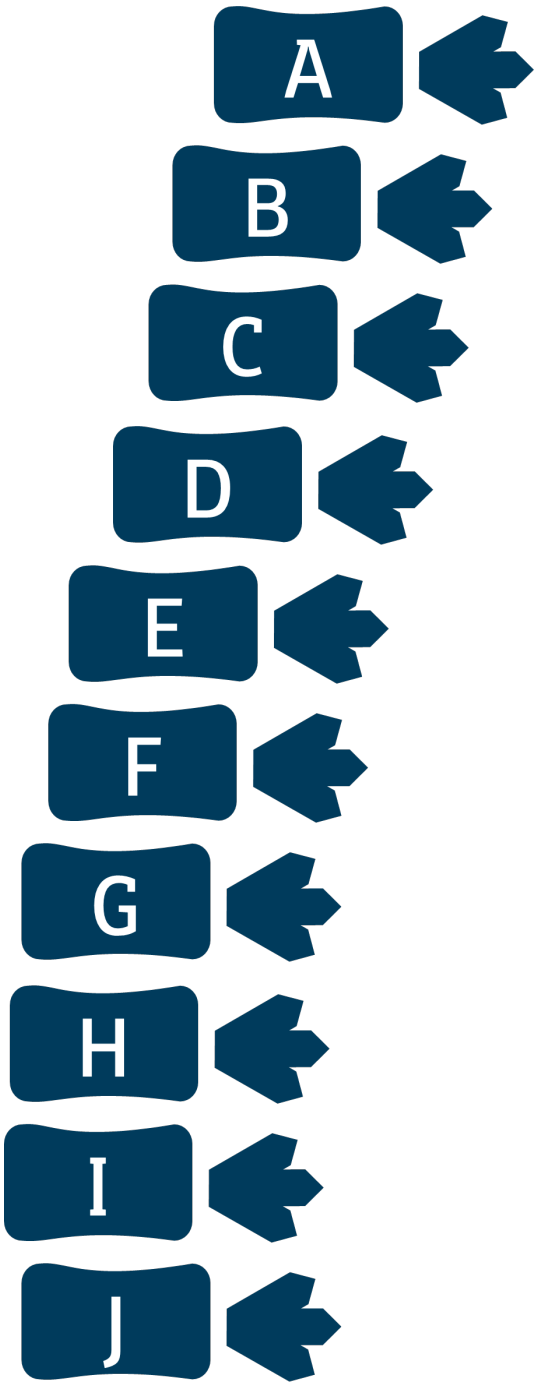

General Chiropractic Council

Introduction

About the General Chiropractic Council

The General Chiropractic Council is the UK regulator for the chiropractic profession and has the statutory responsibility for setting the Standards of Professional Practice (comprising both the Standards of conduct, performance and ethics; and the Standards of proficiency) that all chiropractors must follow.

Chiropractors are professionals, regulated by the General Chiropractic Council, and the Code of Professional Practice defines what is required of them across the full range of different settings where they work and the range of roles that they have.

The purpose of the Code of Professional Practice

The values, Principles and Standards within the Code of Professional Practice form the reasonable expectation that everyone - the public, patients, other health care providers and other chiropractors - can have of a registered chiropractor. A chiropractor can go above and beyond these Standards in their practice, but they must meet them.

The Code of Professional Practice is addressed to chiropractors but will assist anyone who wishes to understand the duties and responsibilities of the profession.

The number of Standards in each Principle varies, some have fewer than others. The number of Standards, their order within a Principle, and the level of their detail are not indicators of the weight or priority given to the Standard.

Standards and Principles relate to both professional behaviour and professional proficiency, and encompass expectations of both action and of knowledge.

For chiropractors:

The Code of Professional Practice is a framework to help you provide safe, high-quality care in the best interests of patients. It promotes conduct and care that meet the reasonable expectations of patients.

As a healthcare professional you have a responsibility to ensure the care and safety of patients and the public; and uphold professional standards in all aspects of your professional and personal life. You are professionally accountable and personally responsible for your practise (what is done or not done) no matter the direction or guidance given by an employer or colleague. You must be able to justify your decisions and actions. If someone raises a concern about your fitness to practise, you will be expected to demonstrate that your decision making was informed by these Standards and that you acted in the best interests of the patient. You must also comply with all legal requirements that apply to you as a healthcare professional – including (but not limited to) health and safety, data protection, equality, advertising and consumer protection.

For patients and the public:

The Code of Professional Practice sets out what you can reasonably expect of a chiropractor. It puts you, as the patient, at the centre of your care, recognising you as an individual with diverse needs. The Code of Professional Practice supports safe, high-quality care for all. It aims to ensure that you are treated fairly, with respect and dignity, and that your best interests are the priority throughout the care process.

Chiropractors are highly-trained autonomous healthcare professionals. This means that they combine their own knowledge and experience, clinical evidence and your personal healthcare goals to recommend and provide a plan of care personalised to your needs.

The profession provides care to thousands of patients every day and most chiropractors will meet the Standards and Principles set out in the Code of Professional Practice as a matter of course.

Good communication between you and your chiropractor will lead to a stronger therapeutic relationship and help the chiropractor provide you with the best care that they can. If you have a concern about your care, you should first raise it with your chiropractor to give them the opportunity to explain their approach.

The structure of the Code of Professional Practice

The Code of Professional Practice follows a values-based approach by:

1. Identifying an agreed core set of shared values (between patients and chiropractors) that underpin the Code of Professional Practice.
2. Translating these core values into high level Principles. These Principles form part of the Standards and describe actions necessary to implement and realise the values.
3. Setting out more detailed Standards that are necessary to achieve each of the core Principles within the Code of Professional Practice.

The Values

Patients and chiropractors identified four core values:

- Patient-centred care
- Honesty, Integrity and Transparency
- Safety and Quality
- Professionalism

As the Code of Professional Practice is built around these shared values, it reflects the reasonable expectations that patients can have of their chiropractor, and how chiropractors will act as members of the profession. The values are realised through ten high level Principles.

The Principles

Each Principle is equally important in defining what constitutes an acceptable level of professional practice. Although the table highlights the values most associated with each Principle, other values may also apply to each Principle depending on the context.

As a chiropractor:

Principle		**Reflecting the values of:**
A	You must put the interests of patients first	Patient-centred care; Safety and Quality.
B	You must ensure safety and quality in clinical practice	Safety and Quality.
C	You must act with honesty and integrity and maintain the highest standards of professional and personal conduct	Honesty, Integrity and Transparency; Professionalism.
D	You must provide a good standard of clinical care and professional practice	Patient-centred care; Safety and Quality.
E	You must establish and maintain clear professional boundaries	Safety and Quality; Professionalism.
F	You must obtain appropriate, valid consent from patients	Honesty, Integrity and Transparency; Patient-centred care; Safety and Quality; Professionalism.
G	You must communicate professionally, properly and effectively	Honesty, Integrity and Transparency; Safety and Quality; Patient-centred care; Professionalism.
H	You must foster collaborative healthcare, effective professional relationships and safe, supportive workplace practice	Safety and Quality; Patient-centred care; Professionalism.
I	You must maintain, develop and work within your professional knowledge and skills	Safety and Quality; Professionalism.
J	You must maintain and protect patient information	Safety and Quality; Professionalism.

The Standards

A chiropractor must meet all of the Standards within each Principle. By doing so it is anticipated that they will uphold each Principle.

As an autonomous healthcare professional, a chiropractor will use professional judgement in applying the Standards. They will use their knowledge, skills and experience, referencing the Standards and other sources of guidance. In doing so they will practise ethically and in the interests of patients.

How each chiropractor meets the Standards will depend on their role, their workplace and their own individual scope of practice. There will be more than one way of meeting the requirements of each Standard.

The words “You must” are used to indicate that a Standard is mandatory. The word “should” is used where a Standard will not apply in every situation or circumstance.

Supplementary guidance

In relation to some Standards or Principles the GCC may produce supplementary guidance where we feel it may be of assistance.

Whilst there is an expectation that guidance will be followed unless there is a good reason not to do so, there may be other acceptable ways to secure the same outcome required under the Code of Professional Practice.

Each year (as part of the process to retain registration) all chiropractors are asked to confirm that they are keeping up to date with the supplementary guidance published by the GCC.

We draw attention to the extensive glossary which helps understanding of the responsibilities and duties set out within this Code of Professional Practice.

How the Code of Professional Practice and guidance informs Fitness to Practise investigations

Most chiropractors uphold high professional standards but, on occasion, a small proportion fall short. If we receive an allegation that a chiropractor has not met one or more of the requirements of the Code of Professional Practice (“a complaint”), we are bound by legislation to investigate and decide if this could constitute unacceptable professional conduct. An unintentional or minor breach of a Standard is unlikely to constitute unacceptable professional conduct.

In any subsequent Fitness to Practise procedure, the values, Principles, Standards, glossary and supplementary guidance will all be considered to determine whether there has been a breach of professional standards. The chiropractor will be asked to demonstrate that their conduct, performance and decision making were informed by these Standards and Principles.

The Code of Professional Practice:

Principle A

You must put the interests of patients first

The interests of the patient come first, making the care and safety of every patient the priority. The chiropractor's duty of care towards them is fulfilled by promoting their safety and wellbeing, treating them fairly and with respect, and acting to safeguard them. Providing patient-centred care enables their interests to be met. This means listening to each patient, helping them to be involved in reaching decisions about their care, providing care that is personalised to their needs and empowering them in their care, health and wellbeing.

As a chiropractor you must:

A1 put the patient's needs and safety at the centre of their care.

A2 show respect, compassion and care for the patient. You must find out what matters to them and consider their needs and preferences. You must respond honestly and openly to their questions and must not pressure the patient to accept your advice.

A3 provide care based upon the principles of a person-centred approach by:

i. engaging effectively with the patient through individualised conversations and interactions
ii. enabling and supporting the patient in their care, health and wellbeing
iii. involving the patient in decisions about their care
iv. collaboratively supporting and managing the patient when they have a high complexity of physical, psychological and social factors.

A4 respect the patient's privacy, dignity and their right to choose who is present when their care is discussed and provided.

A5 treat the patient fairly and without discrimination, interacting in a way that respects their choices, diversity and culture.

A6 safeguard children and vulnerable adults by:

- considering their safety and welfare;
- assessing their vulnerability;
- actively looking for signs of abuse.

When you suspect a child or vulnerable adult could be at risk of, or suffering, abuse or neglect, you must promptly follow the established local safeguarding arrangements to report your concern. You must record your suspicions and actions.

Principle B
You must ensure safety and quality in clinical practice

It is essential to ensure that patients are kept safe when visiting any healthcare setting and seeking chiropractic care. Robust systems of safety in practice help keep them safe. These will promote safety, in the interest of preventing harm before harm occurs. Prevention requires chiropractors to recognise safety incidents and to be clear that transparent reporting enables their own learning, and the learning of others, so action can be taken to reduce future risks to patients. Chiropractors need to be prepared to respond to emergencies in practice. They have a duty to act where they have concerns for the safety of any patient.

The accessibility of healthcare matters to patients. Chiropractors need to understand and recognise barriers to accessing healthcare, and how reasonable measures to address these may be taken in practice.

Assuring the quality of care provided is central to the protection of patients. This requires chiropractors to continually look for improvements to the quality of care provided to patients.

As a chiropractor you must:

B1	protect patients by promoting and maintaining a culture of safety, seeking to prevent harm before it occurs.
B2	act promptly and appropriately when you have concerns about the safety of a patient, and record what you did.
B3	practise in a safe, hygienic environment where you actively identify and control risks. You must ensure all equipment you use is safe and meets relevant safety standards. You must plan for first aid and other emergencies.
B4	recognise safety incidents that risk the safety of a patient or another person, or have the potential to do so (“near miss”). You must understand the importance of reporting incidents through a suitable safety system, so that you, and the wider profession, can learn from them.
B5	recognise the importance of promoting accessible healthcare for all patients, and recognise how this can be supported in your practise.
B6	collect, evaluate and use feedback and data about the quality of care of patients to continuously improve your practise.

Principle C
You must act with honesty, and integrity, and maintain the highest standards of professional and personal conduct

Patients must be able to trust chiropractors. A chiropractor justifies the trust of patients and the public, both in themselves and in the profession, by upholding high standards of conduct at all times. Trust is earned by acting transparently and by demonstrating honesty, integrity and candour.

A chiropractor is expected to treat everyone fairly, promoting equality, diversity and inclusion, and to take an active role in tackling inequality and discrimination.

When sharing information, chiropractors are expected to uphold the reputation of the profession by being transparent and accountable. This applies when telling people about their services (advertising and any other promotional activities) and when sharing (or resharing) health information, by any medium. Information needs to be accessible (able to be read or received, and understood, by its intended audience) and must not exploit peoples' vulnerability or lack of health knowledge.

Professionalism also extends to managing one's own health and wellbeing, and to how personal views are expressed in interactions with patients and others. It includes the wider responsibilities of chiropractors as regulated healthcare professionals, including the duty to take action when they witness unprofessional behaviour by others.

As a chiropractor you must:

C1 look after your health and wellbeing, seeking support when necessary. You must protect others from harm caused by the health, conduct or performance of you or any other regulated healthcare professional.

C2 seek appropriate independent advice if you have significant concerns about your own fitness to practise, whether due to issues with health, character, behaviour, judgement or any other matter which may compromise the safety of patients or damage the reputation of your profession.

C3 have appropriate insurance and indemnity cover for the full scope of your own individual practice.

You must be clear with the patient that you are registered with the General Chiropractic Council.

You must be clear with the patient whether each person you employ, manage or lead that has a chiropractic qualification, is (or is not) registered with the GCC or another statutory UK health regulator.

C4 take responsibility, as an autonomous healthcare professional, for keeping up to date with, and following relevant legislation, regulations, codes of practice and GCC guidance.

C5 when telling people about your services, ensure that all information is factual, verifiable, does not mislead, or exploit their vulnerability or lack of health knowledge. Where you delegate this, the accountability sits with you.

C6 ensure health information you share publicly is consistent with the best quality of evidence that is available at the time, and is credible and accessible to the intended audience.

C7 ensure your behaviour is professional at all times, upholding and protecting the reputation of the profession and justifying public trust.

C8 respect confidential information about the patient and preserve their dignity at all times, including online, during remote consultations, and when referring to them anonymously.

C9 be honest, fair, and transparent in your business. Your clinical judgement must not be prejudiced by any personal, financial or commercial interest. You must not ask for, accept, or offer, any inducement that may prejudice the care of a patient.

C10 determine and share a clinical plan of care for the patient separately (and independently) from any financial payment plan.

You must provide a clear contract for any financial payment plan which must include arrangements for refunds for unused care. You must not offer a financial payment plan that extends beyond the amount of care set out in your initial clinical plan of care for the patient. You must not pressure the patient to commit financially to long term treatment.

C11 fulfil the duty of candour by being open and honest with the patient. Inform them if something goes wrong with their care which causes, or could cause, harm or distress. You must offer an apology, a suitable remedy or support, and an explanation of resulting actions.

C12 ensure your personal biases, values and beliefs do not prejudice the care that you provide to the patient, your personal interactions, or your professional reputation.

C13 promote equality, diversity and inclusion, challenge discrimination and seek to tackle inequalities. You must raise concerns about colleagues if you believe they are treating people unfairly, have discriminated against someone or if their personal biases have prejudiced the care they provide.

When raising concerns you must follow the relevant local procedures to maintain the safety of everyone involved.

C14 have a reasonable justification for refusing or discontinuing care for a patient. You must record this. You must explain how they can find other healthcare professionals who could offer care, in a fair and unbiased way.

C15 promptly inform the GCC if, anywhere in the world:

i. you are charged with a criminal offence;
ii. you are convicted of a criminal offence;
iii. you are the subject of a regulatory investigation;
iv. you are suspended, dismissed, refused membership or placed under a practice restriction following concerns about your professional conduct or competence by another organisation (including regulator, insurer, professional body, employer).

C16 cooperate promptly and fully with any formal investigation, inquiry, or complaints procedure into your own professional conduct or performance, that of others or the care of a patient.

You must respond to all reasonable requests from the GCC. If you are informed that you are the subject of a GCC investigation, you must follow any directions you are given by the GCC to assist in a fair and efficient process.

Principle D
You must provide a good standard of clinical care and professional practice

A chiropractor is expected to provide good quality care that is patient-centred, safe and effective, and that is consistent with the current standards for good healthcare practice. This is supported by the use of critical thinking to underpin clinical approaches and integrating the best quality of evidence that is available at the time throughout the care of patients. This means chiropractors are expected to offer plans of care that follow the recommendations of authoritative clinical guidelines, within their own individual scope of practice. They need to have sound justification for their clinical recommendations and decisions about the care of patients and keep these under regular review.

When a chiropractor engages with developments in professional practice, such as new technologies and ways of working, they must do so safely and effectively to ensure benefit to the care of patients.

Chiropractors, given that they are well-placed through their interactions with patients and as health and care professionals, are expected to engage in interventions that support prevention and health promotion for the benefit of individuals and the population.

As a chiropractor you must:

Clinical assessment and diagnosis or rationale for care

D1 take and record a thorough case history for the patient.

D2 find out the patient's goals for their care.

Before commencing care, you must establish planned health outcomes of the care, using recognised outcome measures. You must agree with the patient (and record) how progress towards the planned health outcomes will be measured.

D3 with the valid consent of the patient, carry out an appropriate physical examination, prioritising methods supported by the best quality of evidence that is available at the time. You must explain to the patient (and record) the results of the examination.

D4 ensure that you have the valid consent of the patient for any diagnostic investigation (including imaging) before it is carried out. You must carry out investigation in the health interests of the patient and in a way that minimises the risks to them. You must base the investigation on clinical reasoning, following authoritative evidence-based guidelines and adhering to all regulatory standards.

D5 use the results of your clinical assessment of the patient to arrive at a working diagnosis or rationale for care which you must record and keep under review. You must keep the patient informed, including about any diagnostic uncertainty.

Developing a plan of care

D6 use the findings of the clinical assessment and the best quality of evidence that is available at the time, to propose (and record) a plan of care for the patient. You must tell the patient where your proposals are not supported by evidence of accepted quality and record your rationale and discussions.

D7 inform the patient of the risks and benefits to the proposed plan of care.

You must inform them of alternatives to the proposed plan of care including evidence-based options that may be provided by other healthcare professionals, and the expected natural history (prognosis without any care).

D8 apply evidence-based practice to develop, implement and record a personalised plan of care, in partnership with the patient.

You must record and explain to the patient how progress towards the planned health outcomes of the care will be evaluated and set timescales.

You must obtain and record the valid consent of the patient before implementing the plan of care. You must not propose a plan of care that is excessive or that is not justified by a robust, recorded clinical assessment.

Evaluating and modifying the plan of care

D9 continuously monitor and record the patient's progress towards their planned health outcomes, evaluating and adapting the plan of care to meet their needs.

You must carry out formal clinical reassessments at regular intervals, using recognised outcome measures to evaluate the effectiveness of care, as previously agreed with the patient and set out in their plan of care.

D10 discuss with the patient their progression towards their planned health outcomes, agree any continuation or modification to their plan of care and record valid consent.

Providing care

D11 use evidence-based practice to select and implement safe, appropriate, care that meets the needs and preferences of the patient. This could include:

- manual techniques
- rehabilitative interventions
- psychologically informed approaches
- education and advice

You must encourage and support patients to self-manage their health, signposting them to relevant resources.

D12 with the valid consent of the patient make, receive and implement effective referrals to other healthcare professionals, in the best interest of the patient.

D13 engage in evidence-based interventions that support prevention and health promotion, considering health inequalities, for the benefit of the patient and population health.

D14 understand the risks and benefits to the patient before using any new technology and ensure that clinical care is safe and effective, whether it is provided face-to-face or remotely. You must obtain the valid consent of the patient.

D15 ensure that in promoting or conducting research or using research in practice, you do so ethically and effectively.

Principle E
You must establish and maintain clear professional boundaries

Healthcare professionals occupy a position of power and trust, with respect to patients and others. Patients, and those close to them, must be able to trust that those involved in their care will behave professionally towards them. Power imbalances between colleagues can also exist and must not affect professional conduct (this includes when training or supervising others).

Patients are protected when their chiropractor ensures that all of their conversations and interactions with the patient are confined within the limits set by proper boundaries for the professional relationship. This includes ensuring that patients, and others who accompany them, are treated respectfully and with dignity, that patients feel comfortable with interactions, and that their needs or preferences for chaperones or advocates are considered. This enables care to be provided in effective partnership with the patient.

As a chiropractor you must:

E1 recognise the power imbalances that come with being a healthcare professional. You must not abuse the position of power and trust which you occupy as a professional. You must not pursue or encourage improper financial, emotional or personal relationships. You must not cross any professional boundary: this includes sexual boundaries.

E2 ensure you, and any person you employ, manage or lead, treat all patients, their carers or others accompanying them, with respect and dignity.

E3 explain the reason to the patient and obtain and record valid consent if there is a clinical need for clothing to be removed. You must respect their right to privacy to undress and you must offer the use of a gown.

You must always obtain a patient’s consent if it becomes necessary during examination or treatment for an item of the patient's clothing to be adjusted.

E4 consider the need for (or advisability of) another person to be present to act as a chaperone or advocate - for your own protection and that of the patient.

You must, wherever possible, offer a chaperone if the clinical assessment or care might be considered intimate or where the patient is a child or a vulnerable adult, or where the patient requests one. You must record when you offer or use a chaperone or advocate.

Principle F
You must obtain appropriate, valid consent from patients

Patients have the right to determine what happens to them, and chiropractors have legal and ethical duties to obtain valid consent from the patient, or other valid authority, for clinical, and some non-clinical procedures. For consent to be valid, it must be voluntary, informed (based on accurate information including risks and benefits) and the individual giving consent must have the capacity to make the decision.

As a chiropractor you must:

F1 give the patient necessary, accurate, relevant and clear information in a format that is accessible to them so they can make informed decisions about their health needs and care options. You must take reasonable steps to check that they understand the information given to them.

F2 give due regard to the capacity of the patient to give valid consent, considering that their capacity can change over time.

F3 ensure the consent of the patient is voluntarily given, without pressure, or undue influence.

F4 obtain, and record, valid consent from a patient (or their valid authority) before:

- commencing or amending assessment or care
- involving them in teaching or research
- making a recording of them
- disclosing identifiable information about them (unless there is another lawful basis to do so)

Consent is a continuous process, and you must make ongoing checks that consent continues to be given.

F5 take particular care to obtain valid consent when seeing a child or vulnerable adult, considering if the patient is legally competent to give consent or requires the consent of a parent or valid authority.

Principle G
You must communicate professionally, properly, and effectively

The safety of patients, the quality of their care and the provision of patient-centred care require chiropractors to communicate well with patients, their advocates, carers and family, colleagues, and other healthcare professionals. Duties relating to communication also extend to the wider sharing of information by the chiropractor, as a healthcare professional, through all communication channels.

As a chiropractor, you must:

G1 take reasonable steps to understand and meet the language and communication needs and preferences of the patient, while maintaining their privacy.

G2 communicate clinical information to the patient clearly, sensitively and effectively. You must use language that enhances the care of the patient, promotes their health literacy, and supports shared decision-making.

G3 have visible and easy to understand information for the patient on fees, charging policies and how to make a complaint. This information must include the patient's right to change their mind about their care and their right to refer any unresolved complaints to the GCC.

You must respond promptly and appropriately to any complaints that arise.

If you practise in Wales, you should consider also making information available in the Welsh language.

G4 communicate effectively with other professionals in the interest of meeting the patient's health and care needs and goals. You must only share information with the consent of the patient (unless there is another lawful basis to do so).

G5 tell the patient who is responsible for their care. When arranging for another person to provide their care, you must be clear with the patient:

- whether that person is registered with a statutory UK health regulator;
- who holds accountability for that care.

G6 when communicating online as a healthcare professional (including media sharing, social networking sites and user-generated content), do so responsibly. You must check that information is not misleading, and maintain professional boundaries and public confidence in the profession. Where you delegate this, the accountability sits with you.

Principle H
You must foster collaborative healthcare, effective professional relationships and safe, supportive workplace practice

To keep patients safe, and to ensure the quality of their care, it is essential that chiropractors work well with others, within the workplace, and externally and inter-professionally. This includes maintaining effective and respectful professional relationships to underpin collaboration in the care of patients. Where tasks or duties have been delegated to others to do on their behalf, the chiropractor will remain accountable.

Chiropractors need to be able to work effectively as part of a team (where this is required) to deliver and enhance the care of patients. This may include engaging with the design, delivery or enhancement of healthcare services more widely.

Leadership as a healthcare professional is more than the management or supervision of others, it is an attribute all chiropractors are able to demonstrate. Leadership will mean different things in different roles and there are many ways to show leadership.

Chiropractors are expected to promote a positive culture in the workplace, as well as fulfilling their duty to act upon the poor behaviour of others by following local resolution procedures within their workplace. They are also required to give professional support to others, where appropriate.

As a chiropractor, you must:

H1 collaborate appropriately and effectively with other health and care professionals, to enhance the integrated care of patients.

H2 delegate tasks or duties only if safe and appropriate to do so. You must ensure that the person you delegate to is qualified, competent, and supervised and supported as necessary.

H3 demonstrate effective team working and professional interpersonal relationships as required by your role. This includes contributing to the design, delivery, and improvement of healthcare services.

Your professional responsibility towards colleagues

H4 demonstrate leadership appropriate to a healthcare professional and to your role.

H5 treat others in the workplace fairly and with respect.

You must report, follow-up and escalate concerns, following relevant procedures in your workplace, if you become aware of bullying, harassment, or intimidation. You must act quickly and appropriately where such concerns are raised to you, keeping everyone involved safe. You must encourage and support colleagues to raise their concerns.

H6 report, follow-up and escalate concerns, following relevant procedures in your workplace, where the performance or conduct of colleagues puts others at risk of harm. You must act quickly and appropriately where such concerns are raised to you. You must encourage and support colleagues to raise their concerns.

H7 be prepared, as necessary, to contribute to mentoring, teaching, training and professional development of students and other colleagues. You must allow any person you employ, manage or lead to meet their regulatory requirements.

Principle I
You must maintain, develop and work within your professional knowledge and skills

Chiropractic practice is a lifelong journey that demands continuous growth and the upkeep of skills and knowledge to remain current with advancements in the profession. Chiropractors are required to work within their own individual scope of practice. They are expected to regularly monitor the need to adapt and update their practice, taking responsibility for remaining up to date, and for further developing and improving their professional performance.

As a chiropractor, you must:

I1 engage in reflective practice, seeking feedback and analysing information about your practice and the care that you provide, in the interests of supporting continuous improvement.

I2 regularly consider how to adapt or improve your practice considering new developments, technologies and evidence from research.

I3 routinely seek and critically appraise emerging evidence. You must integrate findings of the best quality of evidence that is available at the time into your practice, to enhance the care of patients.

I4 maintain and develop your competence and performance, taking part in relevant and regular learning and professional development activities. You must be competent in all aspects of your professional work, including in any formal leadership, management, research or teaching role.

I5 recognise and work within the limits of your own knowledge, skills and competence. You must be clear with the patient about your limits.

I6 recognise the roles and expertise of other chiropractors and healthcare professionals. You must refer to them, or seek their expertise, when needed.

I7 not allow another person you employ, manage or lead to take on responsibility for the clinical assessment or care of a patient where it is beyond their level of knowledge, skills, or experience.

Principle J
You must maintain and protect information about patients

Chiropractors are responsible for the personal information they collect and hold on their patients. They must fulfil their duties, as set out in legislation, for the protection of data. They need to be clear about the lawful basis for the disclosure or processing of data, giving access to it where this is required.

Advances in technology pose new risks to the personal information of patients. Chiropractors hold responsibility for keeping up to date with advancing technology in their practice and for taking positive action to prevent improper disclosure or misuse of information about a patient.

Chiropractors are accountable for ensuring that they maintain the health record for each patient, recording the status of their health, and each interaction with them. They are also responsible for ensuring the proper storage, transfer and eventual destruction of patient health records.

As a chiropractor, you must:

J1 adapt to advancing technology, including data sharing, media sharing and social media, to proactively protect the patient's personal information.

J2 be accountable for keeping patient records up to date, legible, and attributable. Your record must accurately represent each interaction with the patient. Retrospective amendments or additions to patient records must be identified clearly.

J3 store patient records safely, and securely (whether physically or digitally) so that they remain in good condition for an appropriate retention period (accounting for the age of the patient and when they were last seen).

J4 have documented arrangements in place to protect or transfer patient records in case of moving clinic, ceasing practise or in the event of your death.

J5 ensure that patient records remain your responsibility, even where a patient has moved, unless you have contractually transferred this responsibility to another healthcare professional or organisation.

Glossary

Terminology	Definition
Abuse (signs of)	Signs of abuse may include: • changes in a person's behaviour; • changes in a person's appearance (looking unkempt, dirty or thinner than usual); • sudden changes in their character; • physical signs (bruises, wounds, fractures or other untreated injuries); • the same injuries happening more than once. The requirement to actively look for signs of abuse means being alert to these and not relying upon receiving frank information that a person is being abused.
Accepted quality (of evidence)	For evidence to be of accepted quality (for example, when explaining proposals for possible care options to patients), there must exist at least one published, peer-reviewed, adequately controlled, experimental human study that favours the care approach proposed, and that is relevant to the patient presentation. It should be noted that the best quality of evidence that is available at the time, while being sufficient to support evidence-based practice, may not reach the required quality threshold for Standard D6 that specifies that you must tell the patient where your proposals are not supported by evidence of accepted quality.
Accessible/ accessibility (healthcare)	Equitable healthcare provision that enables everybody to seek, physically connect and engage with it. This might include: providing information to help people identify a health problem and inform their decision to seek help; facilitating them to seek help and obtain an appointment (for example, communication and booking systems); facilitating patients to get to appointments (for example, flexibility of appointment times available, premises and transportation information); interaction and experience within the practice (including the physical environment, communication, cultural competency, patient experience). Accessible healthcare is of particular importance for people with protected characteristics as it supports the principles of equality, diversity and inclusion.
Accessible (information)	Accessible Information is information which is able to be read or received, and understood by the individual or group for which it is intended. We use this in our Standards to apply to all audiences. Accessibility of information is also of particular importance where people have a disability, impairment or sensory loss that affects their information and communication needs. Accessible information supports wider access to healthcare and the principles of equality, diversity and inclusion.
Accountable	You are completely responsible for what you do and must be able to give a satisfactory reason for it. Where you have delegated responsibilities for tasks to others, you may still be accountable where something goes wrong.
Advocate	Any person who supports a vulnerable or disadvantaged person to ensure that their rights are being upheld in a healthcare context.
Apology	Patients expect to be told three things as part of an apology: what happened? what can be done to deal with any harm caused? And what will be done to prevent someone else being harmed? When offering an apology, a chiropractor is not expected to take personal responsibility for something going wrong that was not their fault and saying sorry is not the same as admitting liability or wrongdoing for what has happened. Our GCC Registrant Guidance, Duty of Candour contains further information about offering an apology.
Authoritative (clinical guidelines)	Clinical guidelines that are produced by the most widely recognised experts in the field. This includes, for example, clinical guidelines developed by the National Institute for Clinical Excellence (NICE), or equivalent bodies.

Best quality of evidence	The findings of the highest quality of evidence that is in existence at the time. The quality level (from very low to high quality) is judged across the available body of evidence addressing a research question. It provides a measure indicating the extent to which one can be confident that conclusions drawn on the basis of the research evidence are correct and not potentially misleading. Quality will be affected by the design of included studies (hierarchy of evidence), but also by the methodological quality within individual studies, and by the extent to which the findings between different studies agree. (see also 'evidence-based' and 'accepted (quality of evidence)').
Boundaries	Boundaries are established to set limits to the professional relationship between the chiropractor and the patient, or the chiropractor and another person. Chiropractors are expected to follow guidance set out by the GCC about maintaining professional boundaries, including, but not limited to, sexual boundaries.
Bullying, harassment or intimidation	Bullying and harassment are behaviours that makes someone feel intimidated or offended. When the behaviour relates to protected characteristics, this is harassment and is unlawful. Intimidation is the action of frightening or threatening someone, usually in order to persuade them to do something that the perpetrator wants them to do.
Candour	See 'duty of candour'.
Capacity	Ability of a patient to understand, remember and consider information provided to them. Note: the legal framework for the treatment of a child lacking the capacity to consent differs across the nations of the UK. It is important that chiropractors operate within the relevant law that applies in the nation in which they are practising.
Care	Interventions by chiropractors that are designed to improve health. These include promoting health, maintaining health, preventing ill health, and addressing health needs.
Carer	A person of any age, adult or child, who provides support to a partner, child, relative or friend who cannot manage to live independently or whose health or wellbeing would deteriorate without this help.
Case history	Detailed account of a person's history which results from the acquisition of information through interview, questionnaires and assessment of medical information.
Chaperone	Person who is present during a professional encounter between a chiropractor and a patient, for example, relatives, carers, representative or another member of the healthcare team.
Child/children	England, Wales, Northern Ireland and Scotland each have their own guidance for organisations to keep children safe. They all agree that a child is anyone who is under the age of 18. A young person generally refers to 16 and upwards.
Clinical assessment	Chiropractor's evaluation of a disease or condition based on the patient's report of their health (that is, their physical, psychological and social wellbeing) and symptoms and cause of the illness or condition, along with the objective findings including examination, laboratory tests, diagnostic imaging, medical history and information reported by relatives and/or carers and other healthcare professionals.
Collaborate/ collaborative healthcare	Involving working together for a special purpose. Collaborative practice in healthcare may involve the participation of patients, their family, carers or advocates, and a diverse team of health professionals, who are involved in a cooperative and coordinated way. This means a chiropractor working effectively with whoever else they need to, playing their part to make sure that the various health and care needs of the patient are integrated and delivered well.
Competence	To possess, and be able to apply, the required knowledge, attitude, and skills.

Complexity (health and social care)	Where the needs of the patient are multifaceted, extending beyond multimorbidity and chronicity of physical health conditions, to also include psychological and/or socioeconomic and/or behavioural factors.
Consent	Permission given by a patient and or their carer to accept a proposed action, after having been informed, as far as reasonably can be expected, of all relevant factors. See also 'valid consent'.
Credible	Able to be believed or trusted.
Critical appraisal	Critical appraisal is the process of carefully and systematically examining research to judge its trustworthiness, and its value and relevance in a particular context.
Critical thinking	The objective analysis and evaluation of an issue in order to form a judgement.
Culture	The way of life of a particular group of people, especially as shown in their ordinary behaviour and habits, their attitudes toward each other, and their moral and religious beliefs. Chiropractors need to be competent in their ability to interact with people from different cultures and respond to their health needs.
Data sharing	Making data available to others. This includes open sharing that make data freely available to the public, as well as more controlled forms of sharing where data is only accessible to certain individuals or organisations. See also social media.
Delegate	Ask someone else to take responsibility for carrying out a task on your behalf. While the responsibility for a task can be delegated, the accountability cannot. This means that where a chiropractor asks someone to carry out a task for them, they could still be held accountable if something goes wrong. Where a chiropractor delegates any aspect of clinical care to someone who is not a regulated professional, they retain accountability for the patient. See also "Referral".
Dignity	Central to person-centred care, the concept of dignity is about recognising, acknowledging and honouring the patient as a human being instead of an object. It is particularly relevant in situations when the patient is not personally present.
Discriminate (discrimination)	To unfairly treat a person or group of people differently from other people or groups of people. This includes treating others differently because of your views about their lifestyle, culture or social or economic status, as well as the characteristics protected by law: age, disability, gender reassignment, race, marriage and civil partnership, pregnancy and maternity, religion or belief, sex and sexual orientation.
Diversity	Recognising and celebrating visible and non-visible differences. It acknowledges the benefits of having a range of perspectives in an organisation's operations and decision-making and taking steps to aid and encourage that diversity.
Duty of candour	The professional responsibility of openness and honesty required of chiropractors with patients when something goes wrong with their care which causes, or has the potential to cause, harm or distress.
Effectiveness of care	The extent to which it achieves its intended effect on the health status of the patient, in the usual clinical setting.
Employ, manage or lead	Within the Code of Professional Practice, this refers to any workplace arrangement where the chiropractor either: gives work to someone and pays them for it; is in charge of, or has the position of supervising someone or directly oversees the work of another person. All cases where one chiropractor employs, manages or leads another chiropractor are included (for example where they are an employee, a self-employed associate, a team member etc).
Equality	Fairness: ensuring that individuals, or groups of individuals, are not treated less favourably because of their protected characteristics. Equality relates to the legal obligations in which organisations must not unlawfully discriminate.
Escalate (concerns)	Involve someone more important or higher in rank in a situation or problem.

Evidence-based	Within the Code of Professional Practice, this is used to indicate where it is required that a care approach should be in accordance with the best available evidence from scientific research that is available at the time. See also 'evidence-based practice'.
Evidence-based practice	An approach to making a clinical decision, by integrating: i) the best quality of research evidence that is available at the time; ii) the clinical expertise of the chiropractor; iii) the values of the patient. Evidence-based practice is in accordance with the amended model of evidence-based medicine used by Sackett et al. [2]
Financial payment plan	A financial payment plan includes any arrangement where the patient enters into a financial contract in advance of care that will entitle them to more than one care visit, product or service. It includes pre-payment, membership models and credit agreements. It excludes direct debit arrangements set up on a 'pay-as-you go' basis.
Fitness to practise	Being able to demonstrate that one is fit to be entered onto the GCC register. The requirements are demonstrating sufficient knowledge, skills and competence, behaving professionally and being in good health.
Goals (of care)	Goals of care are the aims of care for the patient, that are informed by their underlying values and priorities.
Health	A state of complete physical, mental and social wellbeing not merely the absence of disease or infirmity.
Health inequalities	Systematic differences in the health status of different socioeconomic population groups.
Health information	Clinical information or advice relating to the diagnosis, treatment and management of illness, disease or injury, or wider epidemiological information. Health information also covers issues of fitness, diet and lifestyle, illness prevention, health promotion and population health. (see also 'prevention' and 'population health').
Health literacy	The personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health.
Health outcome	0
Health promotion	The process of enabling people to increase control over, and to improve their health. This extends beyond a focus on individual behaviour and towards a range of interventions that can have a positive effect on population health.
Healthcare service	An entity that provides medical treatment and care to the public or to a particular group.
Improper	Not professionally acceptable.
Inclusion	Where people's differences are valued and used to enable everyone to thrive in that organisation. An inclusive organisation is one in which everyone feels they belong without conforming. Everyone's contribution matters, and they have the opportunity to perform to their full potential, no matter their characteristics, background, identity, or circumstances.
Inducement	An act or thing that is intended to persuade someone or something. If someone is offered an inducement, they are given or promised gifts or benefits in order to persuade them to do something.
Inequality	An unfair situation in society, for example when some people have more opportunities, better health etc. than other people. In legislation, equality, diversity and inclusion (EDI) describe principles applied in order to systematically reduce inequalities that arise where individuals, or groups of individuals, are treated less favourably because of their protected characteristics. (see also 'equality', 'diversity', 'inclusion' and 'discrimination').

Informed (consent)	To be informed, the person must be given all of the information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead. If the person is not properly informed, their consent is not valid.
Integrated care	Care that is person-centred and co-ordinated within healthcare settings, across mental and physical health and across health and social care.
Interest(s)	An interest brings advantages to or affects someone or something. Conflicts of interest can arise in situations where someone's judgement may be influenced, or perceived to be influenced, by a personal, financial or other interest. Chiropractors are expected to follow guidance for avoiding, declaring and managing actual or potential conflicts of interest, set out in the Conflicts of Interest joint regulatory statement. [3]
Intimate procedure	Intimate procedures will include examinations of breasts, genitalia and rectum, but could also include any procedure where it is necessary to touch or examine intimate parts of the patient's body, or even be close to the patient. Some patients may have particular concerns about undressing or exposing parts of their body but feel hesitant to speak up.
local (procedures or arrangements)	The written set of instructions for how a specific activity is to be conducted that is in place in a particular part of the country (for example safeguarding procedures), or within a particular workplace setting (for example, raising concerns about the conduct of colleagues).
Leadership	Within healthcare, leadership is a personal attribute, that includes managing yourself. Leadership may also involve working with, or managing others, including patients and their care, staff or a healthcare service. It also includes controlling and improving finance, equipment systems and services. Leadership qualities are set out for all health and care staff, including clinicians, irrespective of their role in The Leadership Framework.
Manual techniques	Manual techniques are hands-on care interventions that include manipulation techniques, mobilisation and soft-tissue approaches.
Media sharing	A social media application or site that enables users to create, store, and share multimedia files. See also Social media.
Must	Unless referenced using the word "should", all duties as set out in the Standards are compulsory.
Neglect	Persistent failure to meet the basic physical and/or psychological needs of a child or vulnerable adult. Neglect is a form of abuse. Examples of how someone may be subject to neglect include (but are not limited to) not being provided with enough food or the right kind of food, or not being taken proper care of (see also 'abuse'. 'safeguarding', 'child' and 'vulnerable adult').
Outcome measure	A tool used to assess a patient's current status. Outcome measures may provide a score, an interpretation of results, or a risk categorisation of the patient. Prior to an intervention an outcome measure provides baseline data. The same tool may be used in serial assessments to determine whether the patient has demonstrated change. Outcome measures provide credible and reliable justification for treatment on an individual patient level. They should be selected for use taking account of their demonstrated reliability and validity and include patient-reported outcome measures and physical function measures. A recognised outcome measure is one that that is either evidence-based, or is otherwise widely used, and accepted by most health professionals in the field.
Patient	Individuals who have been given clinical advice or assessment and/or care by a chiropractor. The term 'patient' has been used to save space and is intended to cover all related terms that might be used such as 'client', 'customer' or 'service user'.
Patient-centred	Being centred upon the patient. See also 'person-centred'.

Patient confidentiality	Right of an individual to have information about them kept private.
Patient Record	See Record (noun).
Personal bias(es)	Means one's favouritism towards, or prejudice against people of a particular ethnicity, gender, or social group that consciously or subconsciously influences one's actions or perceptions.
Personal information (personal data)	Information relating to a person who can be identified or who are identifiable, directly from the information in question; or who can be indirectly identified from that information in combination with other information.
Person-centred	Focussing on the needs of an individual. Ensuring that people's preferences, needs and values guide decisions and being respectful of and responsive to them. Person-centred approaches in healthcare are specified.[5]
Physical examination	The process of evaluating objective anatomic and physiologic function findings through observation, palpation, percussion, auscultation and the application of special tests, including neurological and orthopaedic examinations.[6]
Plan of care (clinical)	Treatment protocol designed to deliver therapeutic benefit to patients following clinical assessment.
Planned health outcome	Is used in the Code of Professional Practice to refer to an identified objective of care in terms of the change in the health status of patient, expected to result from the care.
Population health	An approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities.
Power imbalance	Power imbalance occurs when one person holds more authority or influence. When one person occupies a position of greater power, this is positively associated with trust on the part of others.
Prejudice(d)	Have(had) a harmful influence on something.
Prevention	Providing or arranging care that reduces needs for support among patients and/or their carers, and contributes towards preventing or delaying the development of such needs.
Psychologically informed approaches	Where the theories and techniques of psychology are integrated into health care. Examples include educating patients about pain, motivational interviewing to effect behaviour-change, and graded exposure to exercise and activity in order to reduce fear-avoidance and disability.
Qualified	Someone who is qualified has completed the training, or passed the examinations that they need, in order to perform a particular job or task. During the supervision of chiropractic students on clinical placement, 'qualified' means that they have been assessed by the education provider as competent in any task involving patients that they may perform: this will depend upon the current level of their training.
Quality (of care)	The degree to which health care and/or services for individuals and populations increase the likelihood of desired health outcomes. This includes the requirements to be effective, safe and person-centred and to be delivered in a way that is timely, equitable, integrated and efficient.
Rationale for care	Reasons why chiropractors are providing treatment for a patient.
Reasonable measures (accessibility)	What is reasonable depends on each situation. A chiropractor must consider carefully if the measure will improve accessibility, is practical to make, is affordable and if it could detrimentally impact others.

Reasonable steps (language and communication)	What is reasonable depends on each situation. A chiropractor must consider carefully if they are able to take steps that will enable the language and communication needs of the patient to be met more effectively, and whether these are practical and affordable to make.
Record	(verb) The process of creating a record. In most cases the record should be contemporaneously created with the event that is being recorded. (noun) Document containing personal information and information relating to the clinical assessment and working diagnosis or rationale for care of a patient. Typically, it should include relevant clinical findings, decisions made, actions agreed, names of those involved in decisions and agreement; information provided to the patient, the name of the person creating the record and the date the record was made. The chiropractor is ultimately accountable for the content of the patient record.
Recording	(noun) Something that has been recorded. In our Standards this relates to recordings of patients made in any medium, for any purpose. Examples are: audio recordings, transcripts, videographic or still visual images, the patient record (as is necessary for compliance with the GDPR).
Referral	Transferring of responsibility for care to a third party for a particular purpose, such as additional investigation, care or treatment that is outside the competence of the chiropractor. The accountability for that care sits with the individual who provides the care, while the chiropractor is accountable for their referral decisions.
Reflective practice	The process of gaining insight into one's professional practice by thinking analytically about any element of it. The insights developed, and lessons learned, are then applied to maintain good practice and can also lead to developments and improvements.
Regulated healthcare professional	A person who is registered as a member of any profession to which section 60(2) of the Health Act 1999 applies. See also Statutory UK health regulator.
Rehabilitative interventions	A set of interventions designed to optimise functioning and reduce disability in individuals with health conditions, in interaction with their environment.
Remote consultation	A consultation between a patient and chiropractor that involves an episode of care which does not need face-to-face contact, or the participants to be physically located together. It may not be in real time. This includes telephone, video and online 'written' consultations that use two-way messaging (for example, via SMS, email or an online messaging tool).
Relevant (procedures or arrangements)	See Local Procedures.
Safeguard(ing)	Protecting the health, wellbeing and human rights of people, and enabling them to live free from harm, abuse and neglect. It is fundamental to high-quality health and social care.
Safety incident	Any type of deviation from normal clinical care that may occur and that has the potential to cause patient harm, including, for example, delays in diagnosis or referral, patient accidents while in the clinic setting and documentation errors, as well as adverse events (negative outcomes associated treatment). [7]
Safety standards	Include, but are not limited to those required by IRMER, the HSE, designated standards adopted by the BSI (or other recognised standardisation body). Equipment safety also requires manufacturer's instructions for maintenance, servicing, storage and use to be followed.
Scope of practice	The areas in which a chiropractor has the knowledge, skills and experience necessary to practise safely and effectively.

Self-manage (health)	Manage one's own health condition(s) effectively in the context of one's daily life. Self-management is supported when chiropractors work in ways that ensure that individuals with long term conditions have the knowledge, skills, confidence and support they need.
Service	Any organised system that can contribute to improved health or the diagnosis, treatment, and rehabilitation of sick people. Health services are often formally organised as a system of established institutions and organisations to supply services to respond to the needs and demands of the population.
Shared decision-making	The joint process in which a chiropractor works together with a patient and/or carer to reach a decision about care. It makes sure the person understands the risks, benefits and possible consequences of different options through discussion and information sharing, supporting them to make choices based both on evidence and on their individual preferences, beliefs and values.
Signposting	Actively directing a patient and/or carer to the most appropriate source of help. This may include identifying to the patient a more suitably qualified health or care professional (for example, if their requirement is beyond the scope of practice of the chiropractor), or to resources such as web and app-based portals that can provide authoritative information or support self-help or self-management.
Social media	Includes the use of private messaging, websites and applications that enable users to create and share content, or to participate in social networking.
Social networking	The activity of sharing information and communicating with groups of people using the internet, especially through online platforms that are specially designed for this purpose. This includes workplace, professional of personal groups. See also Social media.
Statutory UK health regulator	Any profession to which section 60(2) of the Health Act 1999 applies.
Team working	The activity of working together in a group with other people.
Technology	A particular method by which science is used for practical purposes. Examples include digital or computerised devices, systems and resources. Artificial intelligence is a form of digital technology.
Telling people about your services	Includes advertising and any other promotional activity (including information on websites, media sharing platforms, given in talks, written content etc).
Transparent	Done in an open way without secrets, so that people can trust that this is fair and honest. This includes being clear about the underlying reasons for, or sources of something. It also requires disclosure of conflicts of interest (financial or non-financial).
User-generated content	Information that an unpaid user publishes online. This includes photographs, videos, blogs, discussion forum posts, poll responses, reviews or comments.
Valid consent	Permission given by a patient and or their carer to accept a proposed action, after having been informed, as far as reasonably can be expected, of all relevant factors. This includes, for example, proposed plans of care, care approaches, investigations, referral to another healthcare provider, participation in research or education, or sharing of their personal information for any reason. For consent to be valid, it should be: i) given voluntarily; ii) be based on accurate information including risks and benefits; iii) the individual giving consent must have the capacity to do so. Where a person does not have capacity to consent to the care, support or treatment a decision should be made in accordance with the Mental Capacity Act. We use 'valid consent', rather than 'informed consent', because when the patient is informed this is necessary, but not sufficient for their consent to be valid.

Valid authority	Somebody with a legal authorisation that enables them to provide consent on the behalf of a patient. This includes individuals with parental responsibility for a child, or with a health and welfare lasting power of attorney for an adult who lacks capacity.
Voluntarily given (consent)	The decision to either consent or not to consent to treatment must be made by the person and must not be influenced by pressure from medical staff, friends or family.
Vulnerable adult	A person over the age of 18 who is unable to take care of themselves or protect themselves from harm or exploitation.
Wellbeing	An individual's experience of their life, and a comparison of life circumstances with social norms and values.
Working diagnosis	A working decision kept under review.

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Code of Professional Practice:
Equality Impact Assessment
and Welsh Language Impact Assessment

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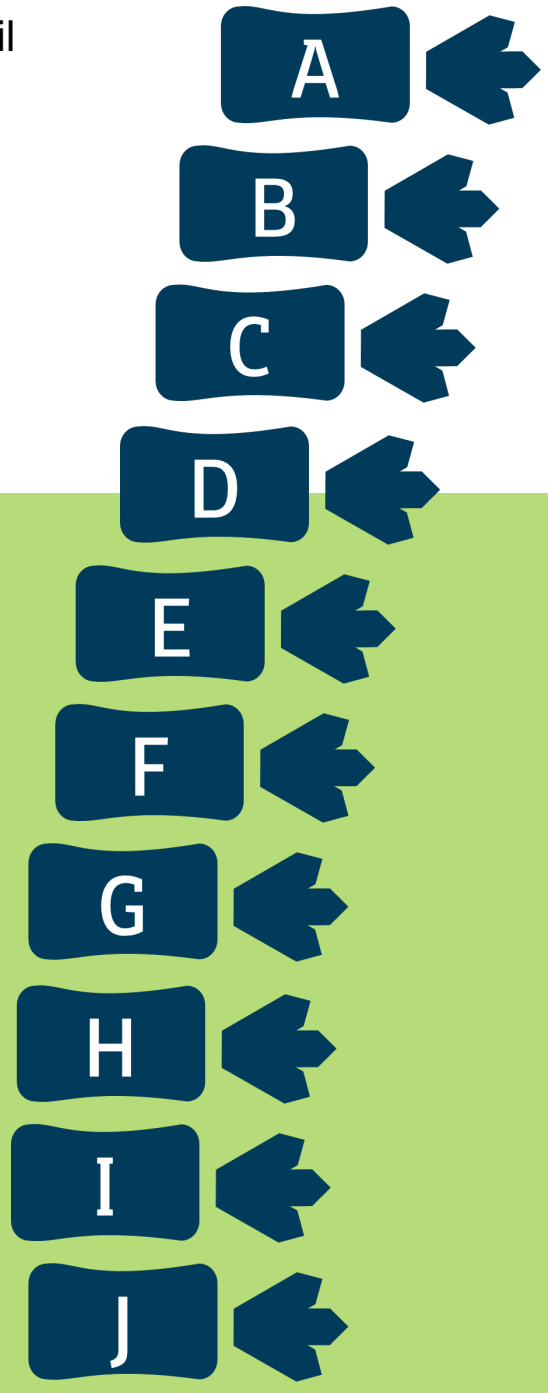


The Code of Professional Practice – Equality Impact Assessment

Step 1 – Scoping the EIA

The term *policy* is interpreted broadly in equality legislation and refers to anything that describes what we do and how we expect to do it. It can range from published policies and procedures to the everyday customs and practices – sometimes unwritten – that contribute to the way our policies are implemented and how our services are delivered.

Title of policy or activity
Review of The Code: Standards of conduct, performance and ethics for chiropractors (2016) and creation of the new Code of Professional Practice.
Is a new or existing policy/activity?
Existing policy
What is the main purpose and what are the intended outcomes of the policy/activity?
The purpose of the Code Review is to • make any necessary updates to the current Standards that reflect changes within health and care practice • ensure that the current Standards are fit for practice, particularly taking accessibility and relevance into account • gain insight into how we can better communicate the Standards and promote them to ensure they are fully understood by registrants
Who is most likely to benefit or be affected by the policy/activity
Once any changes to the Standards are implemented: • registrants will have to meet the new Standards. • education and training providers may need to revise their programmes in line with any revisions to the Standards and teach to the new Code. • international applicants will have to demonstrate they meet these Standards when applying to join the Register. • employers will need to be aware of the revisions to understand what registrants will be required to know, do and understand at the point at which they join the Register. • GCC employees and partners will need to be aware of the revised Standards and apply these in their respective roles eg Registration assessors, TOC assessors, FTP committees Ultimately, patients will benefit from the implementation of the new Standards by creating chiropractors that put the interests of patients first, with patient safety running throughout.

Who is doing the assessment?	
Elizabeth Austin, Education and Standards Officer	
Dates of the EQIA	
• When did it start?	May 2024
• When was it completed?	December 2024
• When should the next review of the policy/activity take place?	Next Code review

Step 2 – Evidence and Engagement

What evidence have you considered towards this impact assessment?
The GCC registrant database has provided us with information regarding the protected characteristics of our registrant population. The scoping review in 2023 and the pre-consultation engagement with stakeholders (the Code Conversation) has provided us with information regarding how the Standards are used and understood in practice. Internal discussions with the GCC Council and other committees have informed these proposals. We sought legal review of the draft revised Standards and have applied their recommendations, and it has been reviewed by our EDI advisor. A communications plan was developed to: • Create awareness and understanding of the review among all stakeholders • To share and disseminate information in a timely fashion • To encourage stakeholders to provide meaningful input into the decision-making process • To generate ideas to be considered and evaluated throughout the process During the consultation period we sought guidance from the GCC EDI Working Group. Members of the group are registrants with expertise in EDI and lived experience. We also sought feedback from patients during the consultation period.

How have you engaged stakeholders in gathering or analysing this evidence?

There were three stages of our stakeholder engagement: pre-consultation; consultation; and post consultation and implementation.

The external stakeholder groups targeted included:

- Professional bodies
- Registrants
- Education Providers
- EDI Working group
- Patients and Patient Interest Groups
- GCC Partners
- Insurance companies
- Students

We carried out a 10-week consultation that included a draft of new Standards based on analysis following our engagement with stakeholders and internal discussions. The consultation asked respondents to reflect on how the draft Standards will impact the service they receive/provide.

Equality, Diversity and Inclusion[1]
The consultation specifically asked for views about the potential positive or negative equality impacts of these proposals and for suggestions for potential mitigations to any identified negative impacts on those with protected characteristics.

Welsh Language Standards[2]
In addition, the consultation specifically asked for views about the potential positive or adverse effects the Code will have on

- opportunities for persons to use the Welsh language
- on treating the Welsh language no less favourably than the English language

and on the mitigations (and potential mitigations) that have been added to the Code to increase the positive effects and reduce the adverse impacts on the same.

We held external stakeholder workshops throughout the consultation period to enhance understanding of the proposals and increase engagement.

We sought feedback on our proposals from the GCC's EDI Working Group.

Proposals were discussed with GCC committees and Council.

[1] *Equality Act 2010*
[2] *Welsh Language (Wales) Measure 2011*

Step 3 – Analysis by protected characteristic

Age (include children and adults)
We anticipate that patients who are vulnerable, which may include children, and adults, are likely to be positively impacted by our proposals. We have proposed updates to Standards regarding assessing vulnerability, safeguarding, consent and professional boundaries (Standards A6, E4 and F5). Children and adults who are vulnerable, may be more susceptible to inappropriate relationships. Proposed changes highlight registrant responsibilities towards their patients and require registrants to be aware of the potential impact of their position on patients, to take an active role in maintaining professional boundaries, and to not leverage their position to pursue or encourage personal, financial, sexual or emotional relationships with patients and/or carers (Standard E1). Proposed amendments and the introduction of new Standards on social media and the sharing of information may also positively impact all patients. The proposed changes require registrants to ensure the information they share is factual, verifiable and not misleading (Standards C4, C5 and C6) and require registrants to protect the privacy of others when posting on social media (Standards C8 and J1). With these changes, we hope to better protect those who are more vulnerable to misinformation and inappropriate content shared on social media applications from harm.

Disability (include people with visible and non-visible impairments and people with many different access needs, for example because of neurodivergence, sight or hearing loss or mobility needs).
We have proposed changes that will be better enable everyone to engage with, and benefit from, chiropractic care by reducing the barriers that they face: • The proposed changes expect chiropractors to recognise diversity, patient choice and interact with patients in a culturally competent way (Standards A2, A5). • Be aware of the potential impact of their values, biases and beliefs, and to take positive action to ensure these do not create barriers for patients, their carers and/or colleagues. (Standards C12 and C13) • Registrants must ensure that they, and the staff they employ, treat all patients, their carers and anyone accompanying them, with respect and dignity (Standard E2). • To provide accessible healthcare provision that everybody can seek, connect and engage with (Standard B5). • Individuals seeking to take advantage of others through an inappropriate relationship are more likely to view those with a disability as vulnerable. We

have proposed updates to Standards regarding professional boundaries (Standard E1). These proposed changes highlight registrant responsibilities towards their patients and require registrants to be aware of the potential impact of their position on patients, to take an active role in maintaining professional boundaries, and to not leverage their position to pursue or encourage personal, sexual or emotional relationships with patients and/or carers. With these changes, registrant responsibilities are clear.

Unlike other protected characteristics, disability brings with it a positive legal requirement in the Equality Act to take steps to remove or avoid something that causes discrimination (e.g. obligations on services providers / businesses to change policies, practices and procedures to ensure access is possible.) Chiropractors are expected to be aware of this legislation (Standard C4).

Gender reassignment
(consider that individuals at different stages of transition may have different needs)

People undergoing or preparing to undergo gender reassignment could be at risk of discriminatory actions, microaggressions or actions which hinder their access to service. We have proposed changes that clarify our Standards, relating to discrimination. We anticipate our proposals will positively impact people with these protected characteristics for the following reasons:

- The proposed changes require registrants to be aware of the potential impact of their views, biases and beliefs on patients, carers and colleagues. Registrants must take action to ensure their own views, biases and beliefs do not lead to discrimination against patients, carers and colleagues (Standards C12, C13 and E2).
- In terms of gender reassignment, this means that where necessary, Registrants and the staff they employ must take action to respect people undergoing gender reassignment which includes using carers' or colleagues' chosen pronouns. (Standards A2, A5 and E2).

In respect to gender reassignment, this will ensure that where necessary, registrants must recognise the importance of adjusting their service to accommodate the individual's need and also ensures that registrants must not restrict access to their services to people undergoing gender reassignment (Standard B5).

People with this protected characteristic may be harmed by breaches in privacy or the spread of misinformation. We anticipate that proposed changes on social media and the sharing of information are likely to positively impact people undergoing or preparing to undergo gender reassignment for the following reasons:

- The proposed changes require registrants to ensure the information they share is accurate and trustworthy (Standards C4, C5 and C6)

- They explicitly require registrants to protect the privacy of others when posting on social media. (J1)

Marriage and civil partnerships
(include same-sex unions)

We have proposed changes that clarify our Standards, relating to discrimination. We anticipate that our proposals will better ensure that people in marriages and civil partnerships are treated equally for the following reasons.

- The proposed changes require registrants to be aware of the potential impact of their views, biases and beliefs on patients, carers and colleagues and to ensure these do not lead to discrimination against patients, carers and colleagues (Standards C12, C13 and E2).

Pregnancy and maternity
(include people who are pregnant, expecting a baby, up to 26 weeks post-natal or are breastfeeding)

We have proposed changes that clarify our Standards, relating to discrimination. People who are pregnant, expecting a baby, who have recently had a baby or who are breast feeding may experience discriminatory actions of microaggressions. We anticipate that our proposals will positively impact those with this protected characteristic by better protecting against discrimination for the following reasons:

- The proposed changes require registrants to be aware of the potential impact of their views, biases and beliefs on patients, carers and colleagues. Registrants must take action to ensure their own views, biases and beliefs do not lead to discrimination against patients, carers and colleagues (Standards C12 and C13).
- Registrants must ensure that they, and the staff they employ, treat the patient, their carer and anyone accompanying them, with equal respect and dignity (Standard E2).
- Where necessary, registrants must recognise the importance of adjusting their service to accommodate the needs of someone who is pregnant, expecting a baby, post-natal or breast-feeding and must not restrict access to their services based on a person being pregnant, expecting a baby, being post-natal or breast-feeding. (Standard B5)

Race
(includes nationality, citizenship, ethnic or national origins)

We have proposed changes that clarify our Standards relating to discrimination. We anticipate our proposals will positively impact those with racialised identities by better protecting against discrimination for the following reasons.

- The proposed changes require registrants to be aware of the potential impact of their views, biases and beliefs on patients, carers and colleagues. Registrants must take action to ensure their own views, biases and beliefs do not lead to discrimination against patients, carers and colleagues (Standards C12 and C13).
- Registrants must ensure that they, and the staff they employ, treat the patient, their carer and anyone accompanying them, with equal respect and dignity (Standard E2).
- In respect to race, this will ensure that where necessary, registrants must take action to adjust their service to accommodate other people's cultural requirements (Standard A5).
- Registrants must not hinder colleagues from practicing their culture at work (Standard C13)
- Registrants must not restrict access to their services based on cultural practices, race, citizenship, ethnic or national origins or nationality (Standard B5)

Religion or belief
(includes religious and philosophical beliefs, including lack of belief)

We have proposed changes that clarify our Standards, relating to discrimination. We anticipate our proposals will positively impact people's choice to hold religious belief or retain a lack of belief by better protecting against discrimination for the following reasons:

- The proposed changes require registrants to be aware of the potential impact of their views, biases and beliefs on patients, carers and colleagues. Registrants must take action to ensure their own views, biases and beliefs do not lead to discrimination against patients, carers and colleagues (Standards C12 and C13)
- Registrants must ensure that they, and the staff they employ, treat the patient, their carer and anyone accompanying them with equal respect and dignity (Standard E2).
- In respect to religion and belief, this will ensure that where necessary, registrants must recognise the importance of adjusting their service for those who practice religious beliefs and also ensure that registrants must not restrict access to their services based on belief or lifestyle choice (Standard B5).
- Registrants must not hinder colleagues practising their beliefs at work (Standard C13).

With these changes, people are less at risk of discriminatory actions based on the religious beliefs they hold or if they do not hold any religious belief. They are also less likely to experience microaggressions. For patients, their access to services is less likely to be hindered because of discrimination.

Sex (Male and female)
We have proposed changes that clarify our Standards, relating to discrimination. Our proposals will positively impact people by better protecting against discrimination. • The proposed changes require registrants to be aware of the potential impact of their views, biases and beliefs on service users, carers and colleagues. Registrants must take action to ensure their own views, biases and beliefs do not lead to discrimination against service users, carers and colleagues (Standards C12, C13 and E2). • In respect to sex, this will ensure that where necessary, registrants must recognise the importance of adjusting their service for those who have different requirements based on their sex and do not restrict access to their services based on a patient's or their carer's sex (Standard B5). • Registrants must not treat colleagues differently based on their sex (Standard C13).

Sexual orientation (include heterosexual, lesbian, gay, bi-sexual, queer and other orientations)
We have proposed changes that clarify our Standards relating to discrimination. We anticipate our proposals will better ensure that people of all sexual orientations are treated equally for the following reasons: • The proposed changes require registrants to be aware of the potential impact of their views, biases and beliefs on service users, carers and colleagues. Registrants must take action to ensure their own views, biases and beliefs do not lead to discrimination against patients, carers and colleagues (Standards C12 and C13). • Registrants must ensure that they, and the staff they employ, treat the patient, their carer and anyone accompanying them, with respect and dignity (Standard E2). • Proposed changes to Standard J1 on social media are anticipated to positively impact people who do not wish their sexual orientation to be disclosed to others. The changes require registrants to protect the privacy of others when posting on social media.

Step 4 – Analysis of impact on Welsh Language

Welsh Language speakers
In line with the GCC's duties under the Welsh Language Standards, the Code has been drafted to have a neutral or positive effect on opportunities for persons to use the Welsh language and to treat the Welsh language no less favourably than the English language. Specifically, the section of the Code relating to communication (Principle G) has been enhanced. It now explicitly references understanding the patient's language and communication preferences as well as their needs (Standard G1). Standards G2 and G3 highlights the need to communicate clearly and in a way that is easy to understand. Standard G3 specifically emphasising that clinic policies could be published in the Welsh language. The new Code, along with the commentary, consultation and consultation documents, will be available in Welsh, and we will be specifically asking every respondent if they are a Welsh speaker (even if responding in English) and whether they live in Wales to ensure the outcomes of the consultation reflect the views of Welsh speakers and Welsh residents.

Step 5 – Other identified groups

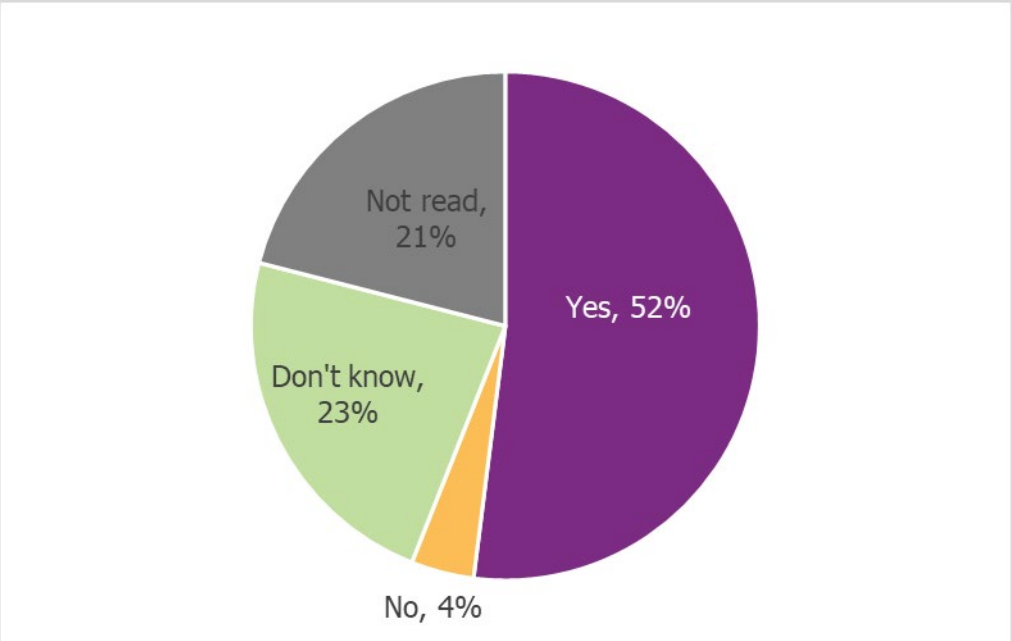
Socio-economic group and income
There is a lack of GCC data relating to registrants' socio-economic group and income. This creates challenges in the assessment of registrants experiencing disadvantage or barriers to access based on socio-economic group or income. Furthermore, socio-economic group and income were not areas of concern raised during our pre-consultation stakeholder engagement. Nevertheless, one of the topics of concern in the pre-consultation has been around financial plans and the possible positive or negative impact of imposing Standards on them for patients who struggle financially. There is an argument that they make care more affordable, while others argue they exploit patients who are in pain. Standard C10 requires clear contracts for financial payment plans, which must include the arrangements for refunds for unused care. This Standard is expected to assist financially vulnerable patients to better understand their responsibilities when signing up with a plan but does not extend expectations of the chiropractor beyond those expected by other regulators. Standard G3 expects chiropractors to have visible and clear information on fees and charging policies (among other things). Standard E1 expands the definition of boundaries to include financial boundaries, to prevent the exploitation of financially vulnerable patients.

Four countries diversity
The Code needs to interface with the legal framework within all the countries where the GCC has registrants. Standard C4 sets the expectation that the chiropractor will keep up to date with, and follow, the laws that will affect their practice in the country in which they work. It does not make explicit links to specific laws or regulators so that it can be applied to all jurisdictions. Standard C15 has been redrafted to remove references to specific legal processes in order to reflect a wider range of circumstances across different legal jurisdictions. It is not expected that the changes proposed will impact any one of the four countries differently.

Step 6 – Summary of analysis

We anticipate the proposed changes to the Standards to have an overall positive impact on people's protected characteristics, their use of the Welsh language and their experience of chiropractic care. Our changes to the identified Standards above ensure that registrants must be active in ensuring their behaviour is anti-discriminatory and ensure that registrants understand that they must actively maintain professional boundaries. This is expected to positively impact children and older people who are vulnerable or those with a disability. Our proposals to strengthen our approach to social media are designed to ensure that registrants understand their role in tackling misinformation relating to protected characteristics such as race, disability, sexual orientation and gender reassignment. There are also new Standards around upholding the dignity of the patient – meaning that registrants cannot post discriminatory or inappropriate content even if the patient is not identifiable within the post. Our proposals specifically encourage chiropractors working in Wales to consider the Welsh language as part of their need to communicate clearly and in a way that is easy to understand. This is a substantial development from the current Code in line with the importance placed on the Welsh language by the Welsh Government. There is also the potential that registrants with disabilities, such as people who are neurodivergent or who have comprehension challenges, and students who may be less familiar with GCC and our Standards may find it challenging to digest the changes proposed. Activities that will help to lessen this impact will include targeted engagement post-consultation. The focus group meetings and review of feedback from the online consultation process allowed us to review the data in more detail and assess any impact on stakeholders with a protected characteristic.

Step 7 – Action Plan

Summary of action plan
Throughout the pre-consultation, consultation and post-consultation period of the review, we engaged with a diverse range of stakeholders. We have engaged with the GCC EDI Working group to ensure that EDI issues relating to the Standards are raised and mitigated promptly. We will continue to engage with this group post-consultation. Their input will be particularly helpful to plan the implementation of the proposed changes and to ensure this is done so fairly across protected characteristics and nationally. Our implementation plan will be especially important and will consider how the new changes are communicated to our external stakeholder groups.
What is the impact of the policy/activity over time?
The effect of the updated Code will be monitored over time and the need for further guidance and toolkits.
Where/how will this EIA be published and updated?
The EIA was published on our website alongside the updated Standards and guidance
Feedback on EIA from consultation responses
The majority of respondents who were able to give an opinion felt that the Equality Impact Assessment accurately describes how the Code could impact on those with protected characteristics (119 respondents).      Further information (including views on the EIA document in relation to the Welsh language) can be found in the GCC Code consultation feedback report.

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This document is also available in Welsh.
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General Chiropractic Council

For approval

GCC Business Plan 2025

Meeting paper for Council on 5 December 2025

Agenda Item: 10

Purpose

A role of Council is to set and monitor the delivery of the GCC's corporate strategy and the delivery of the annual business plan. The paper proposes the GCC Business Plan for 2025, including the key performance measures for tracking its delivery and is for approval.

Recommendations

Council is asked to approve the proposed

- Business Plan 2025 (Annex A)
- Performance Measures (Annex B)

Introduction

1. In September 2021, Council approved the GCC Strategy for 2022 – 24, which set out the organisation's priorities and aims for the three years ending December 2024. It outlines the path to the achievement of:

    - Placing patients and their care at the centre of all GCC work
    - Promoting continuing chiropractic best practice and professionalism
    - Regulating effectively, efficiently, innovatively and inclusively
    - Enhancing the nature and form of regulation for the profession for the future

2. At its September 2024 meeting, Council reviewed the proposed shape of the 2025 Business Plan. It was noted that this iteration would differ from previous versions to allow a strategic 'gap' until Spring 2025, as work on the 2025 – 30 Corporate Strategy is completed.

3. As such, the 2025 Business Plan acts as a strategic bridge, ensuring continuity while laying the foundation for future priorities.

Proposal

4. The plan is designed to ensure the GCC continues to fulfil its core regulatory duties while focusing on high-impact priorities. Building on significant achievements to date, the plan focuses on two central initiatives:

    - **Implementing the revised Code of Professional Practice**, impacting all operational frameworks
    - **Embedding the new case management system (CMS)** within Fitness to Practise investigation processes to enhance efficiency and resilience

5. This plan adopts a leaner and more focused structure, reflecting the need for strategic focus and efficient allocation of resources, particularly as the organisation navigates a period of operational and structural change.

6. By concentrating on fewer but strategically significant initiatives, the plan reaffirms our commitment to placing patients at the heart of our work, supporting registrants in delivering professional excellence, and enhancing the GCC's effectiveness as a regulator. We will do so, alongside the development of the 2025 – 2030 Corporate Strategy through inclusive engagement with stakeholders.

7. The draft Plan is at **Annex A.** In summary, in addition to the central initiatives, the following represent the focus of business plan for the next financial year:

- Undertaking our core tasks efficiently and effectively
- The continued involvement of patients informing our work
- Fostering professionalism and safer care by the development of guidance, toolkits and other activity to promote compliance with standards
- Enhancements to the registrant management system (iMIS)
- Develop a new Equality, Diversity and Inclusion Plan
- Incremental improvements to the Registrant Portal
- Fulfil our governance duties through recruitment
- Implement new service contracts to Partners
- Develop a new Financial Strategy

Recommendation

Council is asked to approve the proposed

- Business Plan 2025 (Annex A)
- Performance Measures (Annex B)

Mary Nguyen

Business and Project Officer

General Chiropractic Council

GCC Business Plan 2025

What we do

The General Chiropractic Council is the UK regulator for the chiropractic profession

The General Chiropractic Council (GCC) is an independent statutory body established under the Chiropractors Act 1994. Its purpose is to develop and regulate the chiropractic profession and protect the health and safety of the public, by setting the highest standards in a Code of Practice, investigating if standards are not met and, where found to be unfit to practise, removing a chiropractor from its Register.

The title of 'chiropractor' is protected by law. It is a criminal offence for anyone to describe themselves as a chiropractor without being registered with the GCC.

Before registration, the GCC checks to ensure all chiropractors, including those from outside the UK, are properly qualified and fit to practise. The Council sets education standards and approves and monitors programmes offered by education providers responsible for the training of chiropractors in the UK.

Through all these activities, the GCC helps to support and raise public confidence in the profession, and its place within the wider health and social care system.

Our Vision, Mission and Values

Vision

To be a respected regulator of a trusted profession.

Mission

To enhance professionalism in chiropractic and promote high-quality care that the public can access safely and confidently, by regulating effectively. Our priorities will be informed by the concerns of patients.

Values

Togetherness: Working as a team within the GCC and with others, appreciating diversity, listening and supporting each other effectively and fairly.

Achievement: Working hard towards a common goal, encouraging and supporting each other, fostering improvement and innovation, and celebrating success.

Accountability: Taking responsibility, using resources wisely and setting clear, attainable targets.

Integrity: Communicating openly and honestly, building mutual respect and trust, having an open mind to reflect and learn lessons.

GCC Strategy 2022-2024 – Extended to Spring 2025

The strategy has four areas of focus each with its own aim and objectives:

	Strategic aims	Strategic objectives
Patients & Public	**To place patients and their care at the centre of all GCC work.**	1A. To gain a greater understanding of patients' needs and expectations so these can be reflected in the work of the GCC. 1B. To promote chiropractic standards that take full account of patients' needs and expectations. 1C. To create, enhance and disseminate information to help patients make informed judgements about their chiropractic care.
Chiropractors	**To promote continuing chiropractic best practice, professionalism and value within the health and social care system.**	2A. To identify, collect and analyse data and insights from regulatory and statutory activity. 2B. To share learning through the gathering and dissemination of GCC internal data and public, patient and registrant research. 2C. To work with education providers and stakeholders to continue the development and promotion of professionalism in registrants, from the start to the end of their careers.
The GCC	**To regulate effectively, efficiently, innovatively and inclusively.**	3A. To act when and where we identify poor practice, from complaints, the misuse of title or when registration requirements, including annual CPD fulfilment, are not met. 3B. To set and promote educational, professional and registration requirements to ensure they remain appropriate and fit for purpose. 3C. To be a sustainable and effective organisation committed to social equality, diversity and fairness.
The Profession	**To enhance the nature and form of regulation for the profession for the future.**	4A. To 'shape the future' of regulation of the profession by influencing the conclusions of the government's consultation and review of health and social care regulation 4B. To foster knowledge sharing and expertise, drive efficiencies and seek opportunities to delegate and/or attain economies of scale. 4C. To take forward the development of rules to be applied upon agreed legislative change.

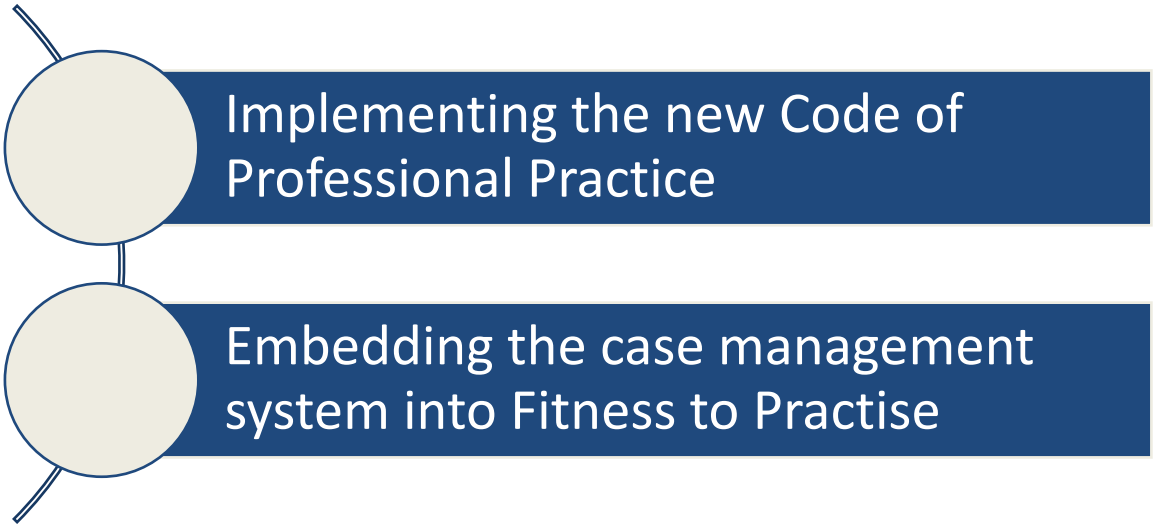
Our priorities for 2025, a strategic transition

The current three-year Strategy was adopted in 2021 and set out our overarching goals for 2022 – 2024. Its development was in response to the evolving landscape of health and social care, and the challenges we face.

With the development and delivery of the new corporate strategy scheduled for spring 2025, the 2025 Business Plan will not only be an extension of the current strategy but also a pivotal step in ensuring that our aims remain relevant and responsive during the transition period.

This Plan represents a pivotal year for the GCC as we bridge the successful delivery of the current strategy with the development of the next one. Recognising the scale and importance of this transitional period, this plan adopts a leaner structure, focusing on fewer, high-impact priorities that will set a strong foundation for our future.

What will this transition look like?



By concentrating on the two core initiatives above, we ensure that resources are optimally allocated to activities with the most meaningful and measurable outcomes.

In addition to the change management, we will develop a Corporate Strategy for 2025 and beyond.

This streamlined approach reflects our commitment to clarity, efficiency and delivering maximum value for our stakeholders while remaining responsive to emerging needs.

If we are successful in achieving our aims in the year, we will see –

- The development of a new Corporate Strategy for 2025 onwards, that reflects the regulatory duties the GCC must undertake as well as doing better where necessary.
- Implementation of the new Code of Professional Practice, providing modern and clear standards and expectations for chiropractors and patients.
- A range of guidance and toolkits linking to the new Code that supports registrants in their learning and reflections on their practice.
- Collaboration, investigation, and business intelligence streamlined with a case management system for the Fitness to Practise team, delivering efficiencies.
- Students embarking on approved chiropractic programmes that align with the new Education Standards.
- A financially sustainable organisation so that we can continue to regulate effectively and protect the public.

Valuing People, Valuing Diversity

At the GCC, we believe equality, diversity and inclusion (EDI) are important to what we do as both as a regulator, and an employer. We want to learn and do better where we can.

In 2022, we developed a 15-point action plan spanning the three years of the Strategy by way of our commitment to EDI across all aspects of the work we do. That has concluded and we will plan develop a new plan that will be woven into the development of the corporate strategy.

We value our team members who, though small in number, demonstrate exceptional dedication and pride in their work, playing a vital role in advancing our strategic goals. Our achievements are made possible by the diversity within our workforce, bringing together a wealth of skills and expertise.

This year, we conducted an organisational review, and we are committed to consider and apply its findings to guide our future development and improvements.

We place patients and their care at the centre of all GCC work

Guidance and toolkits

We will continue to engage with our patient advisory group to inform the implementation of the new Code of Practice and associated guidance and toolkits.

Promote regulation and registration

We will continue promoting the “I’m Registered” mark for the public and assess the outcome and impact the mark has made.

What are the outcomes and benefits?

- Updated information to patients and the public and increased awareness of the *I’m Registered* mark.
- Enhanced protection of patients’ well-being and safety by providing clear guidance to chiropractors on professional boundaries.
- Increased public awareness of the importance of choosing registered and regulated healthcare professionals.

We promote continuing chiropractic best practice, professionalism and value within the health and social care system

Implement the revised Code of Professional Practice

We will update all existing resources, including guidance and toolkits on Consent and Candour, to support registrants to meet the new Code of Professional Practice.

Guidance and toolkits

We will develop new resources that link to the new Code of Professional Practice. If necessary, consultations will also be conducted on new guidance and any existing guidance which is subject to substantial reworking.

Further guidance and toolkits will be developed on diagnostic imaging and maintaining professional boundaries.

GCC-approved qualifications and programmes

We will quality-assure current GCC-approved qualifications and support the development of new programmes and satellite programmes.

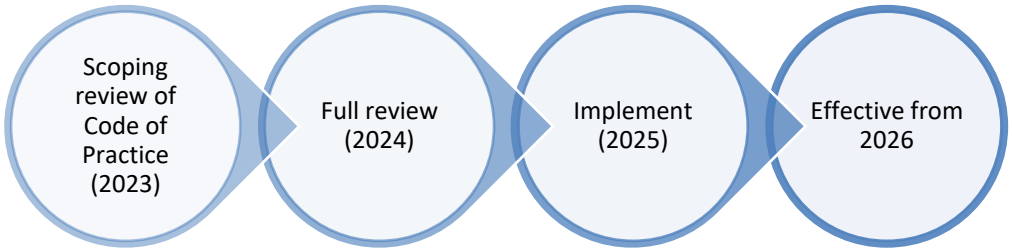
What are the outcomes and benefits?

- Chiropractic qualifications meeting the standards set by the GCC will maintain a high level of education and training in chiropractic care. This will lead to the provision of safe and effective care of patients.
- With the new Code of Professional Practice, there will be an expansion of the range of resources available to registrants to enhance their knowledge, skills and practice.
- Encouragement of a culture of safer care and reporting in the profession, reducing the stigma associated with reporting errors.

We regulate effectively, efficiently, innovatively and inclusively

Implement the revised Code of Professional Practice across the operational and regulatory frameworks

The implementation of this will impact all GCC directorates – Corporate Services, Fitness to Practise, Registrations and Development. Each directorate will review and update resources, policies and guidance to ensure they reflect the revised Code of Professional Practice.



Recommendations from the Professional Standards Authority (PSA)

In response to the recent monitoring report from the PSA, we will take on board the recommendations on areas noted for improvements.

The monitoring report can be found here.

Equality, Diversity, and Inclusion (EDI)

We will develop a new EDI plan that will be woven into the development of the corporate strategy.

Fitness to Practise (FtP) Case Management System

We will see the system go live in early 2025. Afterwards, we will embed it into the Fitness to Practise process by training staff and Partners where

Improvements to the Registrant Portal

We will be working on improving the user experience on the registrant portal (iMIS) for internal and external stakeholders

applicable. We will gain deeper insight into timeliness and broaden our data intelligence to inform our case management.

Deliver Fitness to Practise statutory requirements

We will continue to work towards meeting FtP performance standards and realise the benefits of new arrangements of obtaining clinical advice and in the listing of cases.

Develop a new Financial Strategy

Supporting the new corporate strategy, we will develop a new financial strategy aimed at ensuring the financial sustainability of the GCC and its resources.

Implement new service contracts to Partners

We will introduce new service contracts to Partners that include leave arrangements.

Continuing to fulfil our governance duties through recruitment

The GCC consists of a Council, a number of statutory and non-statutory committees, and several external Partners that support the organisation in our role as a regulator. We will embark on several recruitment drives to both fill and expand membership roles

What are the outcomes and benefits?

- The Code of Practice remains relevant and reflects the high standards expected, benefiting both chiropractors and patients.
- An FtP case management system that enhances efficiency, accuracy and reduce administrative burdens.
- An improved user experience on the registrant portal.
- Compliance with our legal obligations regarding Fitness to Practise, building trust amongst the public.
- Demonstration of a commitment to promote a more inclusive and diverse profession.
- An effective governance structure for regulation, diverse representation, and a broad range of skills.
- Partners will have leave arrangements included in their service contracts
- There will be long-term financial sustainability set out and aligned with the Corporate Strategy

We will enhance the nature and form of regulation for the profession for the future

Corporate Strategy 2025 and onwards

We will focus on developing the next corporate strategy that will set the overarching approach that we intend to follow from Spring 2025 and build on the achievements of the Strategy 2022 - 24. In developing the new strategy, we will ensure that the views of key stakeholders are considered and regulation for the profession is enhanced.

Regulatory Reform

We will keep abreast of any further developments with DHSC and other health and social care regulators.

We will ensure that key stakeholders are informed of any new developments.

What are the outcomes and benefits?

- Where possible, influence and secure legislative change needed to our current powers to improve the effectiveness and efficiency of our regulation.
- Work to shape as far as possible future regulatory frameworks that prioritise safeguarding the well-being of the public through the effective regulation of chiropractic.
- A new corporate strategy for the General Chiropractic Council in 2025.

10 - Annex B – Business Plan 2025 Projects

No.	Project	Measures (KPIs, PSVs, milestones)	Outcomes and Impact
1	**Development of the GCC Corporate Strategy**	**2025 Deliverables and Milestones** 1. Draft Strategy and consultation strategy presented to Council for approval **Q4 2024** 2. Public consultation on draft Strategy with key stakeholders including patients, public and registrants **Q1 2025** 3. Final version presented for approval. **Q2 2025** 4. Publish new Corporate Strategy **Q3 2025** **Project Targets** 1. Corporate Strategy is approved by Council **Q2 2025** **2.** Corporate Strategy is published on the website **Q3 2025**	**Outcomes and Impact (short-medium/long term impact)** 1. The ambitions the GCC seeks in 2025 and onwards are set out clearly.
2	**Implement the new Code of Professional Practice**	**2025 Deliverables and Milestones** 1. Design and publish the document **Q1 2025** 2. Implement across GCC **Q4 2025**	**Outcomes (short-medium)** 1. The Code of Practice is updated and reflects the quality of care expected by patients backed by evidence.

No.	Project	Measures (KPIs, PSVs, milestones)	Outcomes and Impact
			2. Updated professional standards for the chiropractic profession 3. The Code maintains best practice and responds to developments in the profession and wider healthcare sector 4. Revised Code of Practice is published and implemented
		Project Targets 1. By the end of 2025, all GCC resources will be updated to reflect the new Code of Professional Practice including guidance, toolkits and Fitness to Practise processes	**Impact (long term impact)** 1. An updated Code will help registrants adapt to emerging practices and remain relevant in the long-term 2. Reduced complaints from complainants 3. Increased confidence from registrants that the GCC protects the public and ensures high standards of practice within the chiropractic profession [Pulse survey – compare 2023 and 2024 v. 2025 and 2026]
3	**Embedding the case management system for Fitness to Practise**	**2025 Deliverables and Milestones** 1. Complete data take-on **January 2025** 2. Go-live **January 2025** 3. Custom reporting with wider data intelligence **Q2 2025** 4. Update against the new Code of Professional Practice **Q4 2025**	**Outcomes (short-medium term impact)** 1. Increased efficiency by 20% in the management of cases in the FtP team. 2. Improved data integrity and user experience accessing case data by 20% 3. Improvement in communication and collaboration through the system between internal and external stakeholders.

No.	Project	Measures (KPIs, PSVs, milestones)	Outcomes and Impact
			Stakeholder feedback will be sought after gaining experience using the system.
		Project Targets In January 2025, a case management system is integrated into the Fitness to Practise process	**Impact (long-term impact)** 1. Improved data integrity, analysis of data and reporting as the case data is accumulated over time, identifying trends and areas of improvement and reduced risk of errors by 80%. 2. The automated framework will ensure that processes are followed consistently with standardised procedures. – 100%

General Chiropractic Council

For Approval

Proposed Budget 2025

Meeting paper for Council on 5 December 2024

Agenda Item: 11

Purpose

A role of Council is to approve and monitor the delivery of the annual operating budget.

This paper seeks approval from Council of the proposed budget for the financial year ending 31 December 2025. It sets out the expected income and expenditure, material assumptions made and the risks to the achievement of the proposed budget.

Recommendations

The Council is asked to approve the proposed operating budget for the 2025 financial year.

Introduction

1. This report is divided into the following sections:

- Summary
- Overview of income
- Expenditure highlights
- Key budget assumptions
- Unbudgeted cost pressures
- Risks to the achievement of the proposed budget
- Recommendation(s)

Summary

2. With diligent planning, our budget proposal for the 2025 financial year is a "balanced" one, with a small buffer as surplus. That is, the total budgeted income is expected to marginally cover total expenditure for next year. However, it is important to highlight that there are some additional cost pressures which are identified in the paper; but those costs are not included within this budget proposal. We have addressed these 'contingent' cost pressures at paragraphs 20-23 of the paper.

3. The budgeted income for the 2025 financial year is £3.287m (2024 fixed forecast income: £3.256m). This represents an increase in total income of £31k (1%).

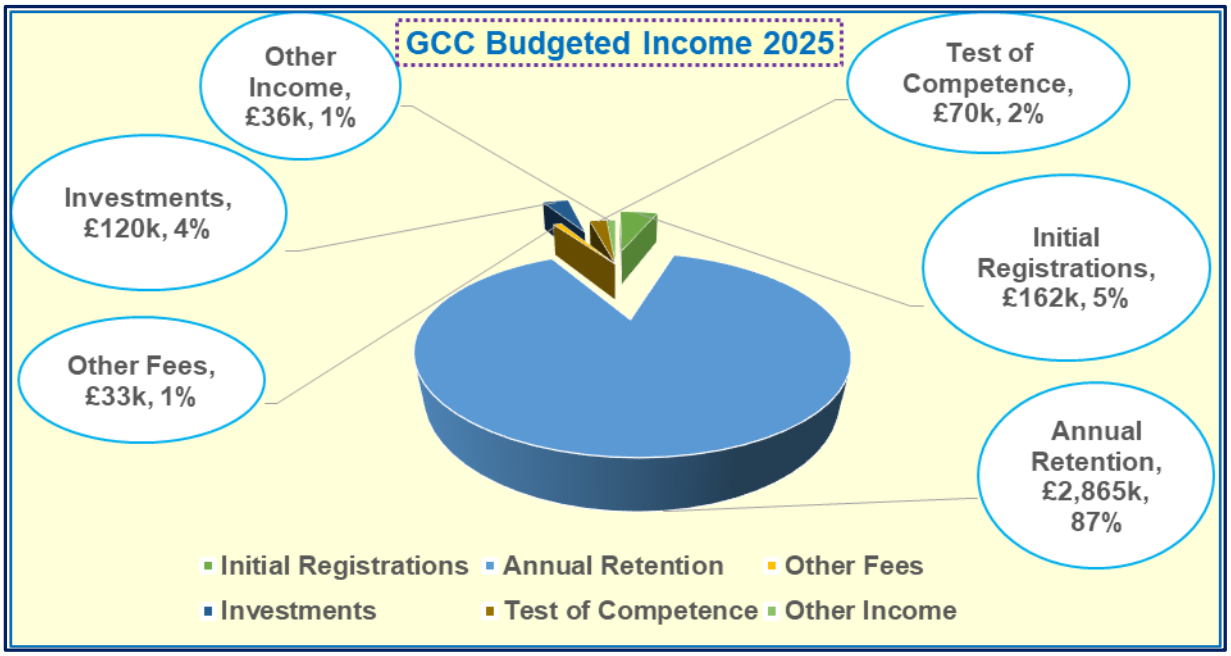
4. The total budgeted expenditure for 2025 is £3.259m compared to the 2024 fixed forecast costs of £3.305m, equating to a reduction in operating costs of 1.4%.

5. The proposed 2025 budget therefore shows a headline surplus of £28k. After adjusting for the budgeted funding of £5k from the restricted reserve, the underlying budgeted surplus is £33k (1% surplus margin).

6. The proposed 2025 budget, if approved by Council, will be reviewed by Council in June 2025 in the light of financial performance in the first half of next year. The report, as approved by Council, will become the forecast income statement for 2025.

Overview of income

7. A breakdown of our total budgeted income of £3.287m for 2025 is set out below:



8. The diagram shows that registrant fee income accounts for 93% of the total budgeted income for next year (2024 fixed forecast: 93%). The other income streams (i.e. investment income, bank deposits interest and test of competence) account for the remaining 7% of the budgeted income for next year.

Expenditure highlights

9. The table below shows the breakdown of the 2025 total budgeted operating costs of £3.259m and 2024 fixed forecast costs of £3.305m.

Expenditure	% (Budget-25)	Budgtet-25 (£)	Fixed Forecast-24 (£)	% (F/Forecast-24)
Salaries and employer costs	36%	1,191k	£1,106k	33%
Central/shared costs	14%	446k	£392k	12%
Lease & Other Property costs	4%	132k	£158k	5%
Regulatory costs (PCC/IC/ISH/PoT)	26%	833k	£1,057k	32%
Regulatory costs (Education/Regns)	15%	498k	£425k	13%
Governance (Council/ARC/RemHR)	5%	158k	£166k	5%
Total Expenditure	100%	3,259k	£3,305k	100%

10. From the table:

- 36% of the proposed budget for 2025 relates to staff salaries and employer costs (fixed forecast 2024: 33%)
- 18% goes on shared and office property costs (2024: 17%)
- 41% is spent on regulating and developing the profession (2024: 45%)
- 5% is on governance (2024: 5%)

Movements between the 2025 budgeted and 2024 fixed forecast operating costs

11. The difference between the total 2025 budgeted expenditure (£3.259k) and 2024 fixed forecast costs (£3.305k) is £46k. We outline in the following table the reasons for the movements.

A	*B*	*C*	*D*	*E*
Cost centre	Fixed Forecast-24	Budget-25	Movement (B less C)	Outline Reasons for Movement
	£'000	*£'000*	*£'000*	
Central Office Services	985	1,037	-52	The Central Office costs are comprised of: • Chief Executive and Registrar's Office • Technology • Human Resources • Corporate Services • Office costs

				Net increase in costs of -£52k is largely made up of the licence and support costs for the new Fitness to Practise Case Management System (costing £66k).
Fitness to Practise (FtP)	1,437	1,262	175	The FtP costs consist of: • Investigations (staff salaries) • Investigating Committee • Professional Conduct Committee (PCC) • Interim Suspension Hearings • Protection of Title The total net decrease in costs of £175k is from: ○ Investigations (£67k) – due to the 2024 temporary staff and secondment costs which we have not allowed for in the 2025 budget. ○ IC (£62k) – caused by expected fewer pre-IC cases being outsourced in 2025. ○ PCC (£70k) – based on the expected number of hearing days next year.
Development	717	803	-86	The Development costs consist of: • Education Committee • Education and Registration (staff salaries and business plan costs) • Quality Assurance • Communications • Test of Competence (TOC) The TOC programme is budgeted to contribute c£3k to our overheads in 2025 (with budgeted income of £70k and costs of £67k). The other areas of increased costs in the Development cost centre are due to the allowance made for legal advice on education and registration matters (-£12k); allowance for new education programme approval visits costs (-£33k); costs of implementing the Clinical Placement Strategy and an allowance for more internal resource for policy work (-£36k).
Other	166	157	9	Other cost lines combined of less than £10k each.
Total	**£3,305**	**£3,259**	**46**	**Total Expenditure**

Key budget assumptions

New expenditure lines introduced from the 2025 budget year

12. We note that from the 2025 financial year, we will be increasing our operating costs base for the first time (allowed for in the proposed budget) by a minimum of c£90k as follows:

- Annual licence and support costs for the FtP new case management system, CMS (£66k).
- Annual depreciation charges arising from the capitalised costs of the new CMS and new laptops for the staff team (last renewed in 2019), £22k.

Business plan projects 2025

13. The proposed 2025 budget includes the business plan (BP) projects to be delivered next year, as considered in the previous agenda item. The total cost of those projects is £105k.

Increase in employer national insurance contributions

14. Our payroll costs have increased by 11% further to the Government announcement in the Autumn Budget that employer national insurance contributions would increase by 1.2% from 13.8% to 15% from next April.

Indicative 2025 pay award for staff

15. We have additionally allowed for an indicative pay award of 3% for the staff team in the budget, subject to funding availability and approval by Council. The total pay award is £38.5k (2024: £38.7k)

Registrants fee income

16. As noted earlier, registrant fee income accounts for 93% (£3.061m) of the total budgeted income for the 2025 financial year; of this, annual retention income is £2.865m.

17. We have assumed in this budget that the total budgeted retention fee income of £2.865m will be received by December 2024. The retention fee income is paid in advance of the start of the financial year. As of 28 November 2024, we had received £2.157m (75.3%) of the budgeted retention fee amount. The working assumption we have made here is that the balance of £708k (24.7%) is expected to be received by 14 December 2024.

18. Consequently, there is the potential risk that the balance of the retention renewal income may not be fully paid by that date. Having said that, we remain cautiously

optimistic that the total retention fee income will be received by 14 December 2024.

Unbudgeted cost pressures

19. It is important that we set out, transparently, areas of potential expenditure – or cost pressures – that we have not included in the proposed budget. It is possible that the following – contingent – costs may occur. Equally, they may not, and we want to be transparent about that.

Temporary staffing allowance in FtP team

20. Council is aware we expended significant resources on supporting performance on progressing Fitness to Practise cases and the staff team further to high staff turnover in the team this year. However, we will start the new financial year with a full staff complement for the team, albeit new. We expect that the new CMS for the team will impact on morale and efficiency.

21. If we were to experience the same high level of staff turnover in the FtP team in 2025, or we were to adjust the staffing model further to a business case analysis, we estimate that we would incur approximately £80k in temporary staffing and secondment costs. We have not allowed for this in the current budget proposal.

PCC hearing costs

22. The PCC hearing costs are caseload driven. We have adjusted the estimated PCC hearing costs for 2025 to reflect, as far as possible, the 2024 year-end forecast hearing costs.

23. A typical PCC case costs c£50k. Given that PCC hearings are caseload driven, if there are more hearings than we have budgeted for, the costs will be higher than the budgeted amounts; and this will have a negative impact on the budgeted surplus for the year. The inverse of this scenario is that the hearings costs will be under-spent, boosting the proposed budget surplus position. In any event, we will have the opportunity to review the proposed PCC costs next May (for Council's consideration and approval in June 2025).

24. Members are reminded that Council previously agreed that any unbudgeted PCC costs are to be funded from the designated reserve. The value of the reserve is £1.2m as of 31/12/23.

Risks to the achievement of the proposed budget

25. If the additional contingent costs outlined at paragraphs 20-23 were incurred next year, the proposed budget surplus of £28k could result in year-end deficit positions of between £52k - £152k respectively (see table below).

Activity	Impact on proposed Budget 2025	Notes
Proposed Budget Surplus 2025	£28k	As proposed (excluding the contingents costs outlined below)
Additional staffing (FtP team) of £80k increase only	-£52k	Current budget surplus less £80k for additional FtP staff costs
Additional staffing costs increase *Plus:* Increase by 2 PCC cases to be heard	-£152k	Total extra costs of £180k (i.e. additional staffing costs of £80k plus 2 PCC hearings costing £100k)

Recommendation(s)

26. The Council is asked to approve the Budget for the 2024 financial year and to note the contingent costs.

Joe Omorodion

Director of Corporate Services

General Chiropractic Council

For noting and approval
(as applicable)

Report from the Chair of the Education Committee

Meeting paper for Council on 05 December 2024

Agenda Item: 12

Purpose

The purpose of this paper is for Council to receive an update from the Chair of the Education Committee, following its meeting on 21 November 2024. Council is also asked to consider the recommendations from the Committee regarding the Stage 5 recognition outcome of the Coventry University degree programme and the recognition of satellite programmes from the Health Sciences University (HSU) and the McTimoney College of Chiropractic (MCC).

Issues arising from Education providers and programmes

1. The Committee took note of the many education related meetings and engagements undertaken by the Executive. It noted the substantive change forms received from HSU, London South Bank University, MCC and Teesside University (TU) relating to a range of issues including staffing changes, institution name and changes to assessments.

2. The Committee noted that the final monitoring visit had taken place to Teesside University on 21 October 2024 and noted the recommendations and commendations from the EV panel.

3. The Committee noted the enrolment numbers for September 2024 and that the majority of providers had experienced a decrease in numbers. This was noted in the context of a general trend in higher education healthcare programmes.

Clinical Placement Strategy update

4. The Committee considered the proposed Clinical Placement Strategy, which aims to provide a framework that supports the consistent delivery of high-quality clinical placements. It received a report on the research and engagement work that had been carried out and agreed the vision, objectives and recommended activities.

Coventry University - Stage 5 Recognition outcome for a new programme

5. The Committee received the report by the Approval Panel following its visit to Coventry University and the response to that report by Coventry University.

6. The Committee agreed to recommend to Council that the proposed chiropractic degree programme at Coventry University be approved with conditions, as set out in the Approval Panel's report, which can be found at **12A.**

HSU London satellite programme recognition

7. The Committee discussed the education visitor panel report and recommendations with the Approval Panel Chair and agreed to recommend to Council that the satellite chiropractic degree programmes at HSU London be approved with one condition following its visit to HSU's London campus and that the part-time chiropractic degree programme in Bournemouth be approved. The approval report can be found at **12A**.

MCC Ulster satellite programme recognition

8. The Committee discussed the education visitor panel report and recommendations with the Approval Panel Chair and agreed to recommend to Council that the satellite chiropractic degree programme at MCC Ulster be recognised with Conditions as set out in the Approval Panel's report. The approval report can be found at **12A**.

Code Review

9. The Committee received an update on the review of the Code of Professional Practice; the formal consultation between 22 July and 27 September and the next steps in terms of finalising the Code of Professional Practice for approval by Council.

Committee Annual Report

10. The Committee discussed and agreed its annual report on the work undertaken by the Committee during 2024. This is presented to Council for noting at **12B.**

Committee Work Plan 2024

11. The Committee noted the work plan for the year November 2024 – November 2025. There was some discussion on the first meeting in 2024 and the desire to extend this meeting to include a development session.

12. The next meeting of Committee is on 01 April 2025.

Catherine Kelly

Chair of the Education Committee

Agenda item 12 - Annex A

Recognition of New Programme and Satellite Programmes

Purpose

The purpose of this paper is to present Council with:

- the report by the Approval Panel following its visit to Coventry University further to Stage 4 of the GCC Quality Assurance Handbook (**Appendix A**)
- the satellite programmes approval report by the Approval Panel following its visit to HSU London **(Appendix B).**
- the satellite programme approval report by the Approval Panel following its visit to MCC Ulster **(Appendix C).**

Recommendations

The Council is asked to:

- agree the recommendation from the Education Committee that the proposed chiropractic degree programme at Coventry University be **approved** with conditions as set out in the Approval Panel's report.

- agree the recommendation from the Education Committee that the proposed chiropractic degree programmes at HSU London be **approved** with one condition, and the proposed part-time chiropractic degree programme in Bournemouth be **approved**, as set out in the Approval Panel's report.

- agree the recommendation from the Education Committee that the proposed chiropractic degree programme at MCC Ulster be **approved** with one condition as set out in the Approval Panel's report.

Coventry University

1. The approval visit to Coventry University undertaken by a GCC Education Visitor Approval Panel was considered by the Education Committee at its meeting on 21 November 2024.

2. The GCC appointed an Education Visitor Approval Panel consisting of Grahame Pope (Lay Chair), Sharon Oliver (Lay member), Daniel Heritage (Registrant member) and Hazel Jensen (Registrant member).

3. Following a desk top analysis, a visit to the campus was arranged for 18 and 19 September 2024 to tour facilities and meet with staff and students.

4. A visit programme, highlighting indicative areas to be covered during the visit and required attendees was agreed in advance.

Approval Visit

5. The Approval Panel, Director of Development and the Education & Standards Officer held a series of meetings with the Senior Management Team (SMT), Course Delivery Team, Clinic Team, stakeholders and students. The Approval Panel discussed the evidence in support of the programme and the intentions of the provider with respect to meeting the Education Standards.

6. A thorough tour of the campus including health and life sciences facilities confirmed that the infrastructure is well-equipped to support the intended programme.

7. The Panel also toured the established sports therapy clinic, which could be used as the chiropractic clinic for the first cohort of students. The use of this shared clinic space will be reviewed as student numbers increase.

8. The Approval Panel concluded in its final private meeting of the day that it was assured that the provider had demonstrated sufficient evidence that all the Education Standards were met.

9. During the final meeting with the Senior Management Team, the Panel Chair fed back that its indicative recommendation to the Education Committee is to recommend the approval of the programme with conditions.

10. While the Panel agreed all Education Standards were met, six conditions were imposed. The conditions set for the programme focus on reviewing the planning for resources required to support the clinical aspects of the programme, stakeholder engagement, and alignment with contemporary chiropractic practices. Recruitment of a qualified chiropractic Programme Lead is also required, with the candidate's CV to be sent to the GCC for review. Annual monitoring visits will continue until the first cohort graduates to ensure ongoing compliance and quality standards.

11. Following the meeting, a report was prepared by the Panel and issued for comment to Coventry University on 12 October 2024, with those to be returned to the GCC by 4 November 2024.

12. The response by Coventry University to the approval report was received on 25 October 2024 and shared with the Panel.

Education Committee considerations

13. The Approval Panel Chair summarised the findings from the desk top analysis and site visit to Coventry University in September 2024. The Panel Chair informed the Committee that the Panel was assured that the provider had demonstrated sufficient evidence that all the Education Standards were met, and the Panel recommended that the proposed chiropractic programme be recognised with conditions.

14. Members raised questions regarding condition one, related to reviewing the planning of resources needed to support the clinical aspects of the programme. In response, the Panel Chair clarified that the Panel had requested a comprehensive implementation plan, which should include a development timeline and the proposed approach to implementing quality assurance (QA) for placements. While these areas were thoroughly discussed during the visit, the Panel highlighted the need to formalise this information in writing. The Chair reassured the Committee that the documentation review required to satisfy condition three is not a substantial undertaking and primarily involves making certain elements more explicit.

15. The Panel Chair assured the Committee that the quality assurance procedures applied to this application were consistent and transparent, aligning with those used for previous applications.

16. The Committee considered the report and information provided by the Panel Chair and agreed the Approval Panel recommendations that that the proposed chiropractic degree programme at Coventry University be recognised with conditions as set out in the Approval Panel's report

Satellite approval programmes: HSU London and MCC Ulster

Background

17. The approval visits to HSU London and MCC Ulster undertaken by GCC Education Visitor Approval Panels were considered by the Education Committee at its meeting on 21 November 2024.

18. After several discussions with the GCC during 2023, HSU and MCC submitted documentation in September 2024 for consideration through the GCC satellite recognition process. Recognition_of_satellite_programmes.pdf (gcc-uk.org) This included the Stage 2 Outline Business Case template and the Stage 3 mapping document, focusing primarily on Section 2 of the Education Standards.

19. The proposed HSU London campus programmes aim to expand chiropractic training access by offering both full-time and part-time MSc Chiropractic (Pre-registration) programmes starting in January 2025.

20. HSU also propose to offer a part-time MSc Chiropractic (Pre-registration) programme at its Bournemouth campus starting in January 2025.

21. The proposed MCC Ulster programme aims to establish chiropractic training on the island of Ireland, by offering a part-time Master of Chiropractic (MChiro) programme starting in January 2025.

22. The GCC appointed an Approval Panel consisting of a lay Chair (Rabia Ahmed) and a registrant member (Mark Webster), who supported HSU and MCC with the implementation of the new Education Standards.

23. Following a desk top analysis, a visit to both satellite campuses were arranged for 3 October 2024 and 8-9 October 2024 to tour facilities and meet with staff and students.

24. Visit programmes, highlighting indicative areas to be covered during the visit and required attendees, were agreed in advance.

Approval Visit HSU London

25. The Approval Panel, Director of Development and the Education & Standards Officer held a series of meetings with the Senior Management Team (SMT), Course Delivery Team, Clinic Team and students. The Approval Panel discussed the evidence in support of the programmes and the intentions of the provider with respect to meeting the Education Standards.

26. During the visit, the Panel toured the campus facilities, including teaching and clinical spaces, student support resources, and administrative offices, confirming that the infrastructure adequately supports the planned programmes.

27. The Approval Panel concluded in its final private meeting of the day that it was assured that the provider had demonstrated sufficient evidence that all the Education Standards were met.

28. During the final meeting with the Senior Management Team, the Panel Chair fed back that its indicative recommendation to the Education Committee is to recommend the approval of the programmes in London with one condition, and approval of the part-time programme in Bournemouth.

Approval Visit MCC Ulster

29. The Approval Panel, Director of Development and the Education & Standards Officer held a series of meetings with the Senior Management Team (SMT), Course Delivery Team, Clinic Team and students. The Approval Panel discussed the evidence in support of the programme and the intentions of the provider with respect to meeting the Education Standards.

30. A tour of the campus and extensive health sciences facilities was also undertaken confirming that the infrastructure adequately supports the planned programme.

31. The Panel reviewed plans for clinical facilities, scheduled to open in 2028, which will integrate with Ulster's existing health services to allow students clinical experience in a multidisciplinary setting.

32. The Approval Panel concluded in its final private meeting of the day that it was assured that the provider had demonstrated sufficient evidence that all the Education Standards were met.

33. During the final meeting with the Senior Management Team, the Panel Chair fed back that its indicative recommendation to the Education Committee is to recommend the approval of the programme with one condition.

Education Committee considerations

34. The Approval Panel Chair summarised the findings from the desk top analysis and site visits to HSU London and MCC Ulster in October 2024. The Panel Chair informed the Committee that the Panel was assured that the providers had demonstrated sufficient evidence that all the Education Standards were met, and the Panel recommended that the proposed chiropractic programmes be recognised with conditions.

35. The Committee considered the reports and information provided by the Panel Chair and agreed the Approval Panel recommendations that that the proposed chiropractic degree programmes at HSU London and Bournemouth and MCC Ulster, be recognised with conditions as set out in the Approval Panel's report.

Action

36. agree the recommendation from the Education Committee that the proposed chiropractic degree programme at Coventry University be **approved** with conditions as set out in the Approval Panel's report.

37. agree the recommendation from the Education Committee that the proposed chiropractic degree programmes at HSU London be **approved** with one condition, and the proposed part-time chiropractic degree programme in Bournemouth be **approved**, as set out in the Approval Panel's report.

38. agree the recommendation from the Education Committee that the proposed chiropractic degree programme at MCC Ulster be **approved** with one condition as set out in the Approval Panel's report.

Next steps

39. If the Council accepts the recommendation for approval of the chiropractic degree programme at Coventry University, a recommendation to Privy Council will be made.

40. Privy Council recommendation is not required for the proposed satellite chiropractic degree programmes.

12A - Appendix A

Education Visitors' Report (Approval of a Programme)

Name of Educational Institution	Coventry University
Programme Name	Master of Chiropractic (MChiro)
Proposed Start Date of Programme	September 2025
Date of Visit	18 & 19 September 2024

Panel Chair	Grahame Pope
Panel Members	Sharon Oliver, Hazel Jensen, Daniel Heritage
Observers	Penny Bance
Panel Secretary	Elizabeth Austin

Introduction

Coventry University made a full Stage 3 programme submission to the General Chiropractic Council (GCC) in March 2024 for consideration by the Education Committee at its April 2024 meeting.

The programme submission was analysed by an Approval Panel (the Panel) consisting of two lay and two registrant Education Visitors.

The Education Committee agreed that the submission may proceed to Stage 4 of the recognition pathway. Given that this is a new programme at a new institution, the Committee decided that the full Approval Panel for that visit would also comprise two registrant and two lay visitors.

On 22 August 2024, the Panel convened to discuss areas requiring further exploration based on their analysis of the programme submission. The Panel focussed on areas in Sections One and Two of the Education Standards that remained 'Partially Met' or 'Not Met', after Coventry's March submission.

Ahead of the Stage 4 visit, the Panel shared an agenda with the University, which included a tour the campus and meetings with senior management, teaching and support staff, potential placement providers and students enrolled on current healthcare programmes.

Staff members, groups, facilities and resources seen			
	Yes	No	N/A
Dean/ pro-vice-chancellor/deputy vice chancellor	☒	☐	☐
Representative(s) from validating institution	☐	☐	☒
Senior management responsible for programme resources.	☒	☐	☐

Programme Leader	☐	☒	☐
Faculty staff	☒	☐	☐
Students*	☒	☐	☐
Patients	☐	☐	☒
Clinic facilities **	☒	☐	☐
Learning Resources (e.g. IT, library facilities)	☒	☐	☐
Other	Please specify		

How areas of concern were addressed.

During the pre-meeting on 22 August, the Panel highlighted areas of interest or concern that had previously been identified in the submission analysis that would be explored in further detail at the visit. During the event these were addressed through a series of meetings with senior staff and stakeholders.

18 September 2024
Tour of facilities

The Panel toured the university campus and teaching facilities, accompanied by the Head and two Associate Heads of the School of Science and an external chiropractic academic who contributed to the programme.

During the visit to the 'Alison Gingell' building, where the chiropractic teaching would take place, the Panel observed paramedic, nursing and midwifery suites, an operating theatre, teaching rooms, breakout / self-study areas and numerous staff offices. They also visited the established sports therapy clinic, which could also be used as the chiropractic clinic for the first cohort of students. The use of this shared clinic space will be reviewed as student numbers increase.

The Panel was also shown a clinical skills plinth room, currently used by physiotherapy, sport and exercise therapy and occupational therapy students, which will also be used for chiropractic clinical training sessions. Plans are in place to purchase chiropractic tables and students would have access to this room outside of their timetabled hours if staff supervision was available.

Additionally, the Panel toured the large library building where they observed the English, maths and academic writing support areas, as well as laptop loan facilities, which the team stated ensures digital equity for students.

Following the tour, the Panel noted that it was evident that significant investment in resources had been made.

Meeting one: Staff responsible for self-directed learning and the virtual learning system (VLE)

The Panel requested an overview of the library systems, available resources and the VLE available to students. The library team outlined the range of both physical and online chiropractic resources already accessible for the programme, presenting specific examples to the Panel. The library team explained they manage the reading lists, secure necessary licenses, and prioritise e-licenses to allow off-campus access for students. Additionally, the team clarified that budgeting for library resources is managed centrally by the school's budget leader, rather than being allocated to individual programmes. The

Panel was given a demonstration of the library system, showcasing its functionality and range of resources. Students are provided with induction sessions tailored to their study level and can book personalised academic support sessions.

The Panel was informed that the University utilises a bespoke online platform called AULA, which plays a central role in student learning and support. AULA includes both module-specific content and broader community pages, where students can engage in discussions by posting and commenting on threads. Digital submission and assessment for written work are integrated into AULA, while practical assessments are conducted in person. The Panel also observed a demonstration of the platform.

Additionally, students have access to Engageli, a platform that supports synchronous and asynchronous collaborative learning, as well as PebblePad, which is used to manage placement handbooks, allowing practice educators to monitor and sign off on students' progress during placements.

The Learning Technology Team assured the Panel that the VLE is fully accessible to all students, including those with specific needs. The team provided examples of the accessibility features with the Panel.

Students are allocated one dedicated "course hour" per week during term time to engage with various support services. This dedicated time encourages collaborative work with different services to enhance their learning experience.

Meeting two: Staff responsible for student support services

The Panel met with representatives from the Student Union, the Talent Team, Student Experience, Phoenix + a student success coach to discuss student support systems.

The Panel enquired about the process for assessing students with additional needs and the range of support in place. The team provided examples of pre-admission strategies that enable staff to monitor and assist prospective students. Once enrolled, the wellbeing team coordinates support for students, ensuring academic staff are informed of necessary accommodations. Attendance and assessment monitoring systems facilitate early interventions for at-risk students, while students can schedule 15 minute appointments with academic staff to address academic concerns. Bursaries and scholarships are available to help students overcome financial barriers.

The team highlighted the self-declaration process for students facing personal challenges alongside a referral system where staff can direct students to the wellbeing team for welfare and mental health support.
The Student Union (SU) representative explained they also offer additional advice on academic, social, and welfare matters and organise Student Voice meetings for feedback on programmes and student experiences. Chiropractic students would be encouraged to join or establish societies, with support provided by the SU.

The Panel was informed that each student is assigned a success coach offering pastoral support and early interventions, through three key touchpoints per semester. This involves support to meet deadlines and manage workloads, access to support services, peer support networks and skills development.

The Panel was introduced to Phoenix +, which aims to bring students together to develop skills and knowledge in a range of areas. Examples of immersive experiences, workshops

and mentorship opportunities focused on employability and graduate skills were shared with the Panel.

Additionally, the team outlined the careers and placement support available through the Talent Team. The team will support the chiropractic placement process, including the consideration of additional needs, before and during placements.

In its private meeting, the Panel commended the university for its comprehensive student support and engagement strategy, as well as the wide range of support services and teams dedicated to helping students succeed in various career paths.

Meeting three: Stakeholders

The Panel met with two key stakeholders: a chiropractic academic who provided expert advice on the programme design and structure, and a clinic owner who toured the university facilities, including the teaching clinic, to discuss and help shape the chiropractic elements of the programme.

The Panel learned that the chiropractic academic played a key role in reviewing and drafting final curriculum documents, offering guidance on integrating chiropractic principles. He emphasised the shortage of chiropractic educators and the need to train future chiropractors who can transition into teaching roles. He also noted that existing staff within the School possess many transferable skills that could be leveraged for the chiropractic programme. He also shared that while there is enthusiasm for the programme within the local chiropractic community, awareness among local practitioners may still be limited.

Both stakeholders and university managers have taken steps to raise awareness, including sending emails to local chiropractors. However, challenges remain regarding local chiropractors' willingness to provide student placements.

When asked about the demand for chiropractors in the area, the stakeholders, despite no formal consultation, expressed confidence in a strong local demand and a sufficient patient base to support the programme.

19th September

Meeting one: Senior Management Team (SMT)

The Panel met with eight members of the SMT from the College of Engineering, Environment and Science and clarified the purpose of the visit and the processes involved in the approval of the programme. Ahead of the Stage 4 visit, the Panel requested the Team to prepare a PowerPoint presentation outlining the vision for the proposed chiropractic programme.

The Associate Head of School for Quality and Accreditation delivered the presentation and shared that the chiropractic programme aligns with the institution's strategic aims, particularly in terms of employability and widening access to healthcare education. The programme seeks to address the growing demand for chiropractors in the UK while benefiting from its location and widening participation in higher education. The programme will leverage existing expertise within the institution, particularly by adopting an interprofessional education (IPE) approach, encouraging collaboration between chiropractic students and those from other healthcare disciplines.

The Panel noted that the chiropractic programme will be housed within the School of Science, part of the College of Engineering, Environment, and Science. When questioned by the Panel about this placement, the SMT explained that the programme shares scientific foundations with existing programmes, such as sports therapy, but also emphasised the strong sense of collegiality within the school. They highlighted that chiropractic students will collaborate with peers from other healthcare programmes, such as physiotherapy utilising shared facilities to foster interprofessional learning.

The SMT emphasised that the practical learning elements of the programme will be delivered in the Alison Gingell building, where allied health profession programmes are based. Staff expertise in core and basic sciences will underpin the chiropractic curriculum. When asked about staff development, the Panel was informed that staff are supported in their professional development through initiatives like the Aspire Programme and the requirement to complete a Postgraduate Certificate in Higher Education (PgCert HE).

Looking forward, the Panel noted the institution's ambition to become the leading chiropractic provider in the UK. There is a strong desire to develop chiropractic research, positioning the institution as an authority in the field.

The Panel noted the recruitment plan, which aims to enrol 20 students in the first year, with growth anticipated over time. While there may be minimal financial losses in the early years, the programme is expected to become profitable as student numbers increase. The institution is committed to teaching out the programme, even if initial recruitment numbers are lower than expected, and is optimistic about attracting both domestic and international students in the long run.

Regarding staff recruitment, the Panel was informed that a part-time chiropractic Curriculum Lead will be recruited to support the programme, with plans in place to help this staff member transition from clinical practice to academia. Two additional full time equivalent positions will also be required. New staff will be encouraged to pursue advanced qualifications, such as a PgCert and potentially a PhD.

The Panel was informed that chiropractic students will initially share the existing Sports Therapy Clinic for their placements, which currently operates twice a week and requires 200 hours of practical experience for sports therapy students. However, the Panel noted that this model would be insufficient to meet the clinical requirements of the chiropractic programme.

The SMT explained that interprofessional learning (IPL) with students from other healthcare disciplines, already exist within the School and shared teaching opportunities have been embedded into the chiropractic programme. While there is potential for collaboration with the School of Health, the Panel noted that these collaborations are not yet fully structured. Additionally, there are opportunities for collaboration with Sports and Exercise students in modules at levels 4 and 6.

When asked about stakeholder and patient engagement with the programme, the SMT explained that the institution plans to continue collaborating with local chiropractors to raise awareness and promote career pathways for graduates. The University also has a well-established service user and carer engagement team, which will be leveraged to involve patients in the programme's development and monitoring, ensuring a strong alignment with real-world healthcare needs.

Students will play an active role in shaping the programme through structured feedback mechanisms. The institution follows a 'You Said, We Did' approach, documenting changes to ensure transparency and accountability.

Meeting two: programme planning and design – Year one

The Panel met with the Course Director for Sport and Exercise Therapy, the Curriculum Lead for Sport, the Head and Associate Head of School for Quality and Accreditation and the external chiropractic academic.

The Panel requested that the programme team outline the philosophy behind the programme structure. The team explained that the chiropractic programme is designed to provide students with hands-on skills early on, providing practical, real-world experience from the outset. As students' progress, they engage with increasingly complex scenarios and research, fostering the development of lifelong skills essential for both clinical practice and broader professional opportunities. This applied approach ensures that graduates are well prepared for the demands of the healthcare landscape.

When questioned about the integration of programme material both horizontally and vertically, the team described the curriculum as a "spiralling" structure and provided examples. This design revisits and expands upon key concepts and skills at various stages of the programme, reinforcing learning and deepening understanding over time.

A key aim of the programme, as outlined by the programme team, is to embed lifelong learning skills, such as adaptability, critical thinking, and innovation. These skills, alongside technical proficiency, aim to ensure that graduates can navigate their career effectively. Additionally, communication skills will be embedded and developed, as they are vital for successful patient interaction and professional growth within clinical environments. The sports therapy team provided examples of how these skills are currently taught and how they will be developed on the chiropractic programme.

The Panel was also presented with examples of technology integration from the sports therapy programme, with plans for shared sessions at level 4 and level 6. Examples to encourage innovation in chiropractic practice, using tools like TENS machines and therapeutic ultrasound machines were provided. However, the Panel noted that while the technology integration shows potential, there is still work to be done to ensure that it aligns fully with the needs of chiropractic practice.

The Panel queried how interprofessional learning will be included in the programme. They were informed that the programme will adopt a multidisciplinary approach after students establish their professional identity in year one. This approach, encourages collaboration across healthcare professions, better preparing students for the realities of practice. Examples were provided to illustrate how this will be implemented.

The sport and exercise therapy team demonstrated a strong understanding of fitness to practice and the Panel agreed that the chiropractic programme could draw from this model to ensure that students are well prepared for the clinical demands of the profession.

Regarding access to practical spaces, chiropractic students will have access to the sports therapy department's facilities, subject to booking in advance. These sessions will be supervised to ensure that the spaces are used effectively and safely. The team hopes this arrangement will foster collaboration between sports therapy and chiropractic students, offering opportunities for shared learning and practical experience.

In its private discussion, the Panel agreed that specific concerns had been addressed, but noted areas for development, particularly in the integration of technology to better support chiropractic students.

Meeting three: Students

The Panel met with three students from a range of healthcare programmes at the University.

During the meeting with the Panel, students expressed overall satisfaction with the academic support provided by their tutors. They appreciated the proactive nature of tutors who offered one-on-one sessions and group tutorials, as well as the quick email responses they received. Students also praised success coaches and support teams, particularly for consistently signposting relevant resources, which enhanced their academic experience.

Pastoral support, especially during placements, was a notable highlight and students reported regular check-ins from tutors to ensure both their well-being and placement progression. The placement experience was generally positive, with students feeling supported by both hospital staff and academic supervisors. They appreciated the clear learning objectives provided and the structured system of inductions, midpoint meetings, and final reviews to track their progress. However, some challenges were noted, particularly in nursing and physiotherapy placements.

Regarding programme feedback and improvement, students found the module review questionnaires helpful, and they acknowledged the introduction of a "traffic light system" to manage workloads. This system was well-received and eventually implemented across other healthcare programmes. Course representatives were actively involved in evaluations, with nursing students providing feedback on the appropriateness of placement levels, which was taken on board by staff.

Interprofessional learning (IPL) was another area where students benefited, particularly in nursing, where child, mental health, and adult branch cohorts worked together on group assessments. Students also collaborated with occupational therapy and midwifery students. There was notable interaction between sports therapy and sport science students in undergraduate teaching. One example of IPL was in mental health studies, where service users with learning disabilities took a "flipped approach" and led a teaching session for students, providing a unique, patient-led experience.

Students noted the value of receiving patient feedback during placements, which they used to inform their reflective practice. Sports therapy students particularly appreciated the experience in the on-site clinic, where they could assess members of the public under supervision, building confidence in their treatment skills.

Employment support services were well-regarded, with students aware of the various resources available to them, such as the Talent Team and Handshake app for job opportunities. While students were less familiar with Phoenix +, they believed it offered extracurricular and employability-focused activities. The student coaches, who remain accessible after graduation, were particularly appreciated for their career guidance.

Library and learning resources were frequently used by students, both in-person and online. They found the resources easy to locate and were familiar with requesting additional materials if needed. Support services like the Centre for Academic Writing and

maths workshops were highlighted as particularly beneficial. Physiotherapy students also made regular use of subject librarians for their studies.

Finally, students reported positive experiences with the university's IT services. Physiotherapy students noted the usefulness of PebblePad as a digital learning tool, and overall, students found the IT support team helpful in resolving any technical issues efficiently.

Meeting four: Programme planning delivery years 2-4

The Panel met with the Course Director for Sport and Exercise Therapy, the Curriculum Lead for Sport, the Associate Head of School for Quality and Accreditation and the external chiropractic academic.

The Panel requested examples and an overview of programme design and delivery, specifically focusing on the integration of the clinical portfolio, research components, leadership skills, and the introduction of concepts related to ceasing care. In response, the University team provided a detailed explanation of how these areas would be incorporated and developed throughout the programme. They also presented the Panel with specific examples to substantiate their approach in addressing each of these key elements.

The programme team discussed plans to integrate diagnostic imaging into the curriculum, including the observation of diagnostic ultrasound, to enhance students' understanding of these tools. They are also exploring opportunities for students to observe advanced imaging techniques such as MRI scans in external settings, which will expand clinical exposure beyond the university environment.

In the later years of the programme, students will be introduced to the management of comorbidities and complex cases, assessed through case-based evaluations. This will help them develop critical thinking and decision-making skills necessary for handling multifaceted patient conditions. Students will also take a ‘Managing a Chiropractic Practice’ module designed to equip them with the knowledge and skills needed to effectively manage and operate a successful chiropractic practice. The module will focus on strategic planning, financial management, and marketing within a healthcare setting.

Additionally, although in its early stages, the team is considering incorporating population health initiatives into the curriculum, which would provide students with a broader understanding of healthcare delivery and prevention strategies.

Meeting five: Meeting with clinic team

The Panel met with the Course Director for Sport and Exercise Therapy, the Curriculum Lead for Sport, the Associate Head of School for Quality and Accreditation, the Associate Dean and the Practice Education Support Unit Manager.

The team was asked to outline the planning process for placements and observation visits. They explained that the programme team collaborates with the university’s Talent Team to ensure placement settings meet health, safety, and educational standards. This process involves regular meetings between the university, placement providers, and students to maintain quality and regulatory compliance. All placement providers sign practice education agreements that outline their roles and responsibilities, ensuring alignment with the university’s standards.

Although discussions regarding external placements are still in the preliminary stages, the team indicated plans to engage local providers more formally once the programme is validated. A thorough assessment of local providers' willingness to participate in chiropractic placements will be undertaken during the programme's implementation phase.

Currently, the sports therapy team use the InPlace placement system to capture feedback from both students and placement providers, with the goal of continually improving the placement experience. This system could also be adopted for the chiropractic programme.

The team acknowledged some uncertainty regarding the supervision model for chiropractic placements and they are currently reviewing practices from other institutions to determine the most suitable approach. It was confirmed that only chiropractors will supervise students during placements, ensuring guidance from professionals with expertise in the field. Chiropractic students will share the existing Sports Therapy Clinic for placements until student numbers increase.

In its private meeting the Panel identified a few policy gaps, particularly around supervision and placement management, that will require further clarification and development as the programme progresses. However, the Panel was reassured that models and processes from other programmes within the School could be adapted to meet the needs of the chiropractic programme.

Account of verbal summary given to the institution

During the final meeting with the Senior Management Team, the Panel Chair stated that its indicative recommendation to the Education Committee is to:

- recommend approval of the programme with conditions

It was agreed that the approval report would be shared with the University for fact checking by week beginning 7 October 2024 for return to the GCC by 4 November 2024. The report will be presented to the Education Committee at its November meeting. If it is agreed that the programme meets all the Education Standards, the Committee will recommend to the Council of the GCC that the programme should be approved.

The Council of the GCC considers and decides whether to accept the recommendation of the Education Committee. The decision of the Council to recognise a new programme is then progressed to the Privy Council, if required, for its approval.

Recommendation to Education Committee	
1. Approve without conditions	☐
2. Approve with conditions	☒
3. No approval (insufficient evidence due to serious deficiencies)	☐

Conditions for the institution with reasons and timeframe in which they must be met.

1. Review the planning for resources required to support the clinical aspects of the programme and provide an implementation plan. This should include a development timeline, the planned implementation of quality assurance (QA) for placements (including any current QA documentation or policies used in other programmes), and a review of clinical hours. To be provided by March 2025

2. Provide a plan for the inclusion of stakeholder groups (eg local Chiropractic community, service users, carers, students) in the design, delivery, monitoring and quality assurance of the programme. To be provided by September 2025.

3. Review the programme documentation (Programme and Module Specifications) to ensure that (i) the content reflects a focus on contemporary chiropractic practice, and (ii) elements such as collaborative practice are more explicit. To be provided by September 2025

4. Produce a plan to enable the ongoing development of IPL within the Chiropractic programme, utilising opportunities both within and outside of the Institution. To be provided by September 2025

5. Recruit an appropriately qualified Chiropractic programme Lead by July 2025
   - The institution must send copies of the individual's CV to the GCC when the appointment of this staff member has been confirmed.

6. The programme will be subject to Annual monitoring site visits until the first cohort of students have graduated.

Recommendations for the institution

1. To look further at embedding digital technology into the programme
2. To build leadership and management skills further into the programme
3. To build on Standards relating to safeguarding, patient centred care and whistleblowing
4. To review language and/or remove content related to historic aspects of care
5. To review the appropriateness of assessments for each module to ensure each ILO is being assessed

Commendations to the institution

1. Comprehensive student support and engagement strategies
2. Wide range of student centred services dedicated to helping students succeed
3. Well thought out teaching spaces available to students

Signed: Grahame Pope (Panel Chair)

Date: 11 October 2024

12A -Appendix B

Education Visitors' Report

Recognition of a Satellite Programme

This form is to be completed by the panel secretary following an approval visit to an institution.

Name of institution	Health Sciences University (HSU) - London
Programme name	MSc Chiropractic Pre-registration programmes (part-time & full-time delivery)
Start date of programme	January 2025
Date of visit	3 October 2024

Panel Chair	Rabia Ahmed
Panel Members	Mark Webster
Observers	Penny Bance
Panel Secretary	Elizabeth Austin

Introduction
After several discussions with the GCC during 2023, HSU submitted documentation in September 2024 for consideration through the GCC satellite recognition process. Recognition_of_satellite_programmes.pdf (gcc-uk.org) HSU completed the Stage 2 Outline Business Case template and the Stage 3 mapping document, focusing primarily on Section 2 of the Education Standards. The Approval Panel consisted of Rabia Ahmed and Mark Webster, who supported HSU with the implementation of the new Education Standards. They were familiar with the programme, having undertaken a comprehensive review of the programme in March 2024. Following a desk top analysis, a visit to the satellite campus in London was arranged for 3 October 2024 to tour facilities and meet with key staff and students.

Staff members, groups, facilities and resources seen			
	Yes	No	N/A
Representative(s) from validating institution			✓
Senior management responsible for programme resources.	✓		
Programme Leader	✓		
Faculty staff	✓		
Students	✓		
Patients			✓
Clinic facilities	✓		
Learning Resources (e.g. IT, library facilities)	✓		
Other	Please specify		

How areas of concern were addressed
During the pre-meeting on 26 September, the Panel highlighted areas of interest that had been identified in the submission analysis that would be explored in further detail at the visit. During the event these were addressed through a series of meetings with senior staff and stakeholders. **Panel meeting with Senior Management Team (SMT)** The Panel met with four members of the SMT. The Panel asked the SMT to provide an overview of the proposed programmes to be delivered at the London campus. The SMT explained that they intend to offer both full-time and part-time MSc Chiropractic (Pre-registration) programmes across the two sites (Bournemouth and London). The London campus delivery and part-time route delivery have the same units, ILOs and course level outcomes as the MSc Chiropractic (Pre-registration) programme, approved by the GCC in 2023. Regarding staffing requirements, The SMT assured the Panel that there is sufficient staffing resource to operate a 'traveling faculty' model whilst the London campus becomes established without detriment to the existing chiropractic provision. This is possible as the MSc Chiropractic (Pre-registration) programme will be taught on opposite days, across the two campuses, to allow staff to travel when needed. A recent survey showed that most staff are open to supporting module delivery at both sites. To manage workload, maximum teaching hours have been set. Additionally, the business plan includes having chiropractic staff permanently based in London after the first semester. The Panel was informed that the part-time route will follow the same units and delivery as provided for the full-time route, but with the units spread over a 3-year period rather than 2 years. The units that students will be expected to take in each year were shared with the Panel. The Panel was informed that students following the part time route will join the full-time students for the units that they are taking, so staffing or delivery of the course will not be affected.

The Virtual Learning Environment (VLE) systems at University College of Osteopathy (UCO) and HSU are currently separate, but the plan is to merge these systems over the next 12-18 months. An IT support team will be based at the London campus to assist with this transition.

When asked about the rationale for establishing a London provision, SMT highlighted market research and growing demand. With LSBU having relocated to Croydon, there is now a gap in central London for this kind of programme, making it appealing to both commuter students and international applicants. The SMT hope its location will open up opportunities for the London campus to become a significant hub for international students. Although the campus at Bournemouth may appear to be a competitor, the SMT believe that the student cohorts differ, and they aim to grow this market in the long term.

The SMT shared plans with the Panel for future development of the London campus. Proposed student enrolments include 20 full-time and 12 part-time students, including six international students. The Panel was informed that staffing levels from Bournemouth are currently sufficient to support these numbers, but should demand grow, new positions will be created. Multidisciplinary expertise will also be shared across other courses to enrich the programme, with plans to introduce leadership and management programmes through a Health Business School. Further programmes, including an MSc in Global Healthcare Management, are being recruited, with post-registration CPD and additional pre-registration courses under discussion.

The SMT shared that they expect a collaborative relationship between the two sites which will foster a shared educational experience, with opportunities for students and staff to learn from one another. The Panel also noted positive discussions with the osteopathy school, which may lead to further collaboration and interprofessional education activities. A strong professional identity for chiropractic students will be maintained through societies and events, with external speakers and online forums connecting both campuses. The SMT stressed the importance of professional identity while encouraging multidisciplinary learning, which is expected to produce more well-rounded practitioners.

Tour of the Campus

The Panel toured both the teaching and clinic buildings and the course team shared plans for upcoming changes to the teaching facilities. The team commented that the London campus is already fully equipped with the necessary estate and teaching infrastructure to support both full-time and part-time formats of the programme. The Panel observed multiple seminar rooms, clinical technique and treatment rooms, a large lecture theatre, a library, quiet study areas, and a dedicated student space that includes a bar and recreational facilities. Faculty and administrative offices include a large open-plan staff office, private meeting rooms, and individual offices for confidential student consultations.

The Panel was informed that the London campus is integrated into HSU's digital infrastructure, enabling all staff and students to communicate via email and

Teams. MSc Chiropractic (pre-registration) students will use Moodle as their Virtual Learning Environment (VLE), accessible from any location.

In addition to its on-campus resources, the London library is linked with the Bournemouth campus, ensuring that students have access to the same online resources. The Library and Learning Services Team has also made provisions for physical books to be added to the London campus collection where e-books are unavailable.

The Panel noted that the chiropractic teaching clinic is scheduled to launch at the London campus in January 2026 and toured the osteopathic clinic, which will house the new chiropractic clinic. Currently, the osteopathic clinic has 34 treatment rooms, and the Panel discussed plans to develop a rehabilitation area. Chiropractic staff will be employed to oversee the chiropractic students on-site, with the Chiropractic Clinical Lead providing oversight from Bournemouth and traveling to London as needed. Final year students will complete their year-long clinical placement at this facility, ensuring they gain practical experience in line with the Bournemouth clinic, though adapted to local patient demographics.

The Clinical Lead explained that chiropractic students will work alongside osteopathy students in a supervised setting, which will foster interprofessional learning and collaboration. As additional healthcare services are introduced at the London campus, chiropractic students will have further opportunities to engage with and learn from other healthcare professionals, enriching their educational experience.

Meeting with the Course Delivery Team

The Panel met with four members of the course delivery team.

The course team provided an overview of the logistics for part-time and full-time provision. The part-time programme will extend over three years, with the content from the programme's first year spread across two academic years. Year three of the programme will align with the full-time programme's second year.

The team confirmed that there would be no difference in resourcing, as teaching and assessments will fit within the current framework. The London campus will be subject to the same QA processes as those at the Bournemouth campus. Practical skills sessions are planned for Mondays and Tuesdays in Bournemouth and Thursdays and Fridays in London. All lecture material will be recorded on the VLE, and while seminars will initially be face-to-face, there is potential for these to move online.

To accommodate the six-week summer placement, plans are in place to establish a London-based equivalent placement. If students are required to attend some or all of this placement in Bournemouth, during the first year, clear communication regarding the funding will be provided at enrolment.

When asked about student access to simulation, the team explained that the London campus currently lacks high-fidelity simulation learning. As a result,

students may travel to Bournemouth for two days of block simulation training, equivalent to what Bournemouth students receive. Alternatively, mobile simulation equipment could be relocated to London if needed.

The Panel was also informed that the Bournemouth campus has a pro-section facility and an Anatomage table, whilst the London campus has a VR anatomy suite and the option for pro-section at Kings College (Guys Campus). Both sites are therefore able to offer anatomy learning with an equivalent learning experience.

Imaging, including MRI and radiography, will also be integrated into the programme, with pre-recorded lectures and live seminars connecting students across campuses. The team emphasised the importance of maintaining parity between the two locations, with the same teaching staff and content.

When asked by the Panel how a sense of community and parity will be developed for the students across both campuses, it was noted that the chiropractic society in Bournemouth will extend its presence to London, offering both in-person and online events to foster a sense of community across the campuses. Additionally, collaborative teaching with external speakers will be made available through online platforms.

Meeting with the clinic team

The Panel met with two members of the clinic team.

When asked about the potential for students at the London campus to see a diverse range of patients, the clinic team explained that there is a strong likelihood of students encountering patients from diverse demographics. This is due to a steady stream of patients already attending the osteopathic clinic, with significant potential for expansion through marketing and health initiatives. The team also plans to replicate the initiatives currently running in Bournemouth, such as outreach to local communities.

The Panel noted that the clinic will open within the first year of the course. A six-week internal placement focusing on patient interaction, triage, and case histories, is scheduled for June & July 2025, followed by the substantive placement which commences January 2026. Leading up to this, staff clinics will be established to create a footfall into the clinic ready for the substantive placement commencing.

The Panel was informed that future plans for the clinic include offering rehabilitation, ultrasound services, and massage therapy, with a focus on fostering multidisciplinary collaboration with osteopaths and chiropractors. External placements will also be organised by the school, with students encouraged to find their own regulated placements. The Panel also noted that while patient fees will contribute to clinic income, it is not expected to cover costs during the initial years.

The team shared that the clinic will provide face-to-face multidisciplinary teaching, with some sessions streamed to ensure all students can access the content. The

goal is to provide equivalent clinical experiences for both part-time and full-time students, with matched levels of clinic supervision across both campuses.

In response to how patients will be involved in the programme, the Panel was informed that the Patient and Public involvement group, already established in Bournemouth, comprises members with a range of interests, including clinical, education, research, and interviewing. The University College of Osteopathy (UCO) has a similar group, and there are plans to merge these initiatives to create a unified approach across both the London and Bournemouth campuses. Utilising the expertise and involvement of the patient group will be crucial in successfully integrating patient involvement into the course at both locations.

Meeting with students

The Panel met with five students from the London and Bournemouth campuses.

The students responded positively to the idea of part-time study, with some expressing that they would have chosen this path if it had been available to them. They saw part-time study as a valuable option for those looking to balance work with their studies, although they acknowledged the intensity of the course content.

When asked to comment on the availability of support services at both campuses, students highlighted the smooth process of accessing support for dyslexia and ADHD in both locations. Students at the London campus highlighted the additional services introduced since the merger, and the facilities – such as the library, VR resources, and treatment rooms, were praised for their accessibility and quality.

While the osteopathy students expressed some initial concerns about maintaining UCO's identity following the merger, they noted that the transition had been smooth, with efforts to preserve the distinct identities of both institutions. Students were particularly excited about the opportunity to work with chiropractic students, as they believe this multidisciplinary collaboration will be beneficial to their future practice.

Meeting with staff responsible for student support / academic administration

The Panel met with four members of the student support/ academic administration team.

The student support team outlined the services available to students. Support is offered online, via phone, or face-to-face, with advertising through the student portal. Students also have access to the Bournemouth support team. Initial triage sessions are conducted to determine the level of support needed, with follow-up sessions available if required. The Students' Union also provides pastoral care, and the Learning Hub and Library are often the first point of contact for students seeking help.

While there are different staffing ratios between the two campuses, the team is actively recruiting additional staff, with funding secured for further roles. The Head

of the library visits the London campus once a week, and the study skills tutor is available to support part-time students on weekends.

Feedback mechanisms, including student engagement surveys and roundtables, are being used to gauge student satisfaction. Plans for larger student numbers are in place, with additional support roles already budgeted. Weekly sessions are held in the Learning Hub to provide students with direct access to support services, ensuring parity between the two campuses.

Account of verbal summary given to the institution
During the final meeting with the Senior Management Team, the Panel Chair stated that its indicative recommendation to the Education Committee is to: • recommend approval of the London campus programmes (part-time & full-time) with one condition • recommend approval of the part-time programme at the Bournemouth campus It was agreed that the approval report would be shared with HSU for fact checking by 25 October 2024 for return to the GCC by 11 November 2024. The report will be presented to the Education Committee at its November meeting. If it is agreed that the programme meets all the Education Standards, the Committee will recommend to the Council of the GCC that the programmes should be approved. The Council of the GCC considers and decides whether to accept the recommendation of the Education Committee. The Panel Chair concluded that subject to approval, the Panel looks forward to returning to the campus once the chiropractic clinic has been established.

Recommendation to Education Committee	
1. Approve <u>without</u> conditions	
2. Approve <u>with</u> conditions	✓
3. No approval (insufficient evidence due to serious deficiencies)	

Conditions for the institution with reasons and timeframes in which they are to be met.
- Develop the London clinic ahead of the January 2026 start date for pre-clinical and clinical training

Recommendations for the institution
- To review staffing and expand as need or demand require. - Review the budget, and provide an updated projection. - Develop resources to run and deliver the programme (including library) appropriately as the cohort grows.

Commendations to the institution
The panel would like to commend: - The management of the transition through the merger. - Planning for student support services - Considerations for parity of the student experience at both campuses, as well as the academic provision. - Widening access to the chiropractic profession through the provision of a part time programme.

Signed

Rabia Ahmed

Panel Chair

Date: 22/10/24

Annex 12A – Appendix C

Education Visitors' Report

Recognition of a Satellite Programme

This form is to be completed by the panel secretary following an approval visit to an institution.

Name of Educational	McTimoney College of Chiropractic (MCC) – Ulster
Programme Name	Master of Chiropractic – (part-time)
Start Date of Programme	January 2025
Date of Visit	8 & 9 October 2024

Panel Chair	Rabia Ahmed
Panel Members	Mark Webster
Observers	Penny Bance
Panel Secretary	Elizabeth Austin

Introduction
After several discussions with the GCC during 2023, MCC submitted documentation in September 2024 for consideration through the GCC satellite recognition process. Recognition_of_satellite_programmes.pdf (gcc-uk.org) MCC completed the Stage 2 Outline Business Case template and the Stage 3 mapping document, focusing primarily on Section 2 of the Education Standards. The Approval Panel consisted of Rabia Ahmed and Mark Webster, who supported MCC with the implementation of the new Education Standards. They were familiar with the programme, having undertaken a comprehensive review of the programme in March 2024. Following a desk top analysis, a visit to the satellite campus was arranged for 8 & 9 October 2024 to tour facilities and meet with staff and students.

Staff members, groups, facilities and resources seen			
	Yes	No	N/A
Principal	✓		
Representative(s) from validating institution	✓		
Senior management responsible for programme resources.	✓		
Programme Leader	✓		
Faculty staff	✓		
Students	✓		
Patients			✓
Clinic facilities	✓		
Learning Resources (e.g. IT, library facilities)	✓		

How areas of concern were addressed
During the pre-meeting on 26 September, the Panel highlighted areas of interest that had been identified in the submission analysis that would be explored in further detail at the visit. During the event these were addressed through a series of meetings with senior staff and stakeholders. **8th October** **Meeting with staff responsible for student support / academic administration** The Panel met with three members of staff with responsibility for student support and academic administration. The Panel queried how students will access student support services while on the programme. The team explained that this would primarily be through MCC. The College aims to ensure that students on this programme have the same experience as other MCC students, with support services and processes clearly outlined in handbooks, the Virtual Learning Environment (VLE), and during induction. The VLE is a key platform for disseminating important messages related to student support. The Panel noted that although students will not use Ulster University's resources for support directly, they may be signposted to them when appropriate. The team explained that every student is assigned a personal tutor, with each campus location having its own tutor for each year group. While the formal route is through personal tutors, students will be encouraged to reach out to any staff member they feel comfortable with. There is a dedicated programme support email box for student issues which the team monitor and respond to. The team shared that the existing student support services are deemed sufficient for the new campus, but provisions are continually reviewed to account for peaks and troughs in demand throughout the academic year.

The Panel queried how staff were supported regarding workloads. The team explained that staff support and well-being are monitored through metrics and data to aid decision-making on staff recruitment. Newer staff members come from backgrounds in well-being support, reducing the reliance on a single individual for student support. Staff expressed to the Panel that they feel well-supported in their roles.

Regarding study skills, the Panel was provided with an overview of the support that will be available to the students, from induction, encouraging students to take an active role in their learning. Guides on referencing and academic writing are available through the VLE, with the learning support manager providing additional support. While Ulster University has its own study support available, MCC services are preferred as they are tailored specifically to the students' needs.

Students will also have access to a well-stocked physical library space on campus, benefitting from resources established for other healthcare courses. Panel members observed this resource during the campus tour and noted that it was a highly adequate resource.

Students will be classified as associate students of Ulster University, granting them access to all facilities on the Ulster campus.

Campus overview and tour

The College's MChiro programme will be taught on the Health Sciences Faculty, Magee campus, of the University of Ulster in Londonderry/Derry. The Panel toured the facilities and observed a range of health sciences programmes including diagnostic radiography, podiatry, speech therapy, the medical school and the dedicated premises allocated to the chiropractic programme. The programme lead for medicine confirmed that the chiropractic students would have access to the anatomy teaching facilities, including the anatomage tables.

The Panel was informed that because the programme is largely delivered at a weekend when the University is very quiet, thought has been given to how chiropractic students can make the most of their time on campus. The plan is that teaching on a Friday will take place in the physiotherapy department, within the health sciences building, and on each Saturday and Sunday, dedicated premises are being made available in the Nursing and Midwifery Council testing facility in Foyle House, a short walk away, where teaching and practical training will take place. The Panel observed the ample space for the chiropractic provision, with opportunities for expansion, if larger cohorts are recruited over time.

The SMT confirmed that all necessary equipment such as chiropractic benches have been ordered and these will be available in advance of commencement.

Following the tour, the Panel noted it was evident that Ulster University had made significant investment in its resources.

<u>Clinic facilities</u>

The College's chiropractic training clinic will commence in 2028, the year before it is needed, for final year interns. The Panel toured the established podiatry in-house clinic and learned that plans are currently being developed for a large multidisciplinary clinic to incorporate occupational therapy, physiotherapy and speech and language therapy. The Principal informed the Panel that the chiropractic programme has requested six treatment rooms within this new facility.

9 October 2024

Panel meeting with Senior Management Team (SMT)

The Panel met with five members of the Senior Management Team

The Panel was informed that in line with its experiences in developing its satellite campuses in Manchester and Madrid, the Ulster campus will be based on centralised administrative functions, integrated use of existing teaching staff to ensure equivalency of delivery, and increasing employment of local teaching and administrative staff as the programme develops.

Operating the model used to start and establish the Manchester and Madrid campuses, the College will utilise local staff as well as staff from Abingdon and Manchester to teach the curriculum. Based on its location, Ulster University faculty staff will teach basic science modules in year one and year two of the programme. The Principal shared that this model ensures the quality of delivery is comparable across multiple delivery sites, as well as providing the platform to establish and grow local staff for the future.

The structure of the programme involves teaching on Fridays, Saturdays, and Sundays once a month over four years, followed by a fifth year dedicated to a full-time clinic.
Nine members of staff from MCC and three from Ulster University will teach across the years, with the current programme lead based in Abingdon.

The Principal shared that this ensures the content is fully covered by experienced faculty and supports not only programme quality assurance but also interaction and engagement between staff in different locations.

The Panel was informed that the Northern Ireland programme will fall under their established quality assurance processes to ensure all aspects of the curriculum, teaching quality, student progress and outcomes, are measured, reviewed and actioned to assure the student experience and the overarching educational consistency of the programmes.
Likewise, students on this programme will complete the same assessments, at the same time as students on other campuses to ensure equivalency of outcomes and are subject to the same criteria for progression and appeals. Assessment review takes place across all programmes and is implemented across all programmes if changes are made.

The SMT shared that all clinical training will follow the policies and procedures of the student community clinics in Abingdon and Manchester. The Clinic Manager in Manchester will have responsibility in Ulster for training new clinic supervisors,

overseeing the equivalency of clinical training between campuses and also for oversight of the establishment of the new clinic.

The Panel was informed that although marketing for this year started later than planned, there has been notable interest, with 152 expressions of interest and 10 strong leads from prospective students. The SMT expect to enrol around 15-20 students once the programme is fully established, with six students being the break-even number. Interest has come from both Northern and Southern Ireland, and there is significant potential to further develop the programme and raise its profile. There is an aspiration to introduce a full-time programme in the coming years.

Regarding input from local stakeholders, the Panel was informed that the primary stakeholder is the Chiropractic Association of Ireland, with whom MCC has been in discussions for over four years. The Association supports the introduction of a part-time model to widen participation to chiropractic studies. Local chiropractors have shown enthusiasm, particularly in supporting student observations. Two large clinics in Londonderry/Derry have expressed a keen interest in hosting these observations. However, since the students won't all be based in Ulster, placements will also be sought closer to students' home locations.

Regarding internal placements, the SMT explained that the Ulster campus will offer placements for chiropractic students in the physiotherapy and podiatry clinics. The Head of School stated that the University's strong Interprofessional Education (IPE) ethos applies to the chiropractic programme and they work closely to ensure all students learn together. In addition, the University offers multidisciplinary Spring and Summer schools.

The Panel asked the SMT to explain what staff support was in place for members of the College who regularly attended the different campuses throughout the UK and Europe. The SMT informed the Panel that MCC has been actively building its faculty over the past few years, and the staff see their roles as developmental opportunities. The majority of the faculty are associate faculty members, many of whom are scaling back their own chiropractic practices to focus on becoming educators. Across the college, there are around 70 associate faculty members.

Every student year group is assigned a personal tutor as the first point of contact for support. If issues escalate, they are directed to senior staff, who ensure that faculty members receive appropriate support. MCC has also factored in travelling time for staff, adjusting timetables to accommodate it. For example, following a visit, staff are not timetabled for the next day, offering a buffer to manage workload effectively. The faculty remains adaptable to change, ensuring staff well-being is prioritised if circumstances shift.

The Panel noted that discussions are ongoing regarding collaborations between MCC and Ulster for research initiatives. There is also the potential for staff to begin PhD programmes. The SMT hope this collaborative approach will enrich the academic environment and provide valuable research opportunities for staff.

Meeting with the Course Delivery Team

The Panel met with seven members of the course team, including three lecturers from Ulster University

The Panel queried how the relevant legislative, regulatory, policy and healthcare differences between Northern Ireland and mainland UK would be taught and assessed. The team responded that, similar to the Madrid programme, the programme will align with GCC regulations, ensuring that all staff members are well informed of their responsibilities in business law and ethics. The programme will cover relevant legislation for both mainland UK and Ireland, including consideration of both Irish and Northern Irish laws.

The team shared that The MChiro will be taught in line with the five year MChiro taught in Abingdon and Manchester which also commences in January each year. The final year clinic will commence in January 2029 and complete in December 2029.

The Panel was informed that teaching will be predominantly face-to-face, once a month on a Friday, Saturday and Sunday during the pre-clinic years with some online sessions when appropriate. Faculty members will provide adaptable resources for individual lecturers, while central programme notes will be available to ensure all learning outcomes are met, regardless of the teaching location. Teaching will utilise a blend of face-to-face, synchronous, and asynchronous learning formats. Additionally, support from the technical team will be available to assist students with any technical difficulties.

Regarding assessments, the team stated that the assessment strategy remains consistent across the programme, with assessments centrally produced and implemented. While efforts will be made to synchronise exam timings across locations, a secondary bank of exams will be available to accommodate differing schedules if required. All examinations undergo a rigorous internal review by the exams committee, followed by external checks to maintain high standards in the marking process.

When asked how the Ulster programme will benefit from being delivered on a larger campus, the team highlighted the benefits from the extensive resources at Ulster University to foster interdisciplinary collaboration among various healthcare disciplines. Plans are underway to explore teaching links across healthcare courses, while ensuring parity of delivery across all campuses. Currently, shared teaching initiatives are being piloted in summer schools, utilising resources such as Anatomage tables and promoting interaction among students. The Panel noted that the Human Function module has been successfully taught by Ulster University staff, and there is a strong desire to further develop this collaboration by integrating staff from the first year of the programme.

When asked by the Panel how a sense of community and parity is achieved across the campuses the team explained that building a supportive community is crucial, with staff playing a key role in this endeavour. The programme lead for year one will facilitate online combined classes, and students will attend the

Manchester and Ulster summer schools together. As with students on other campuses, students on this programme can access funding for trips and accommodation to allow them to feel part of the wider McTimoney community.

Furthermore, discussions regarding research and staff development are ongoing between the Director of Research and Ulster University, focusing on opportunities for both students and staff. Plans to develop a PhD programme are also underway.

Meeting with the clinic team

The Panel met with two members of the clinic team who provided an overview of how the clinic will be set up and run.

The new building, currently under construction, is set to house a multidisciplinary clinic that will integrate physiotherapy, occupational health, speech therapy and chiropractic. The chiropractic training clinic will commence in 2028, the year before it is needed, to build a patient base. Two students who are currently enrolled on the Manchester programme, but based in Northern Ireland, will complete their clinical year at the Ulster campus in 2028 to test the clinic model - similar to the implementation in Madrid.

The team explained that the Clinic Manager in Manchester will have responsibility in Ulster for training new clinic supervisors, overseeing the equivalency of clinical training between campuses, and for oversight of the establishment of the new clinic. The clinic is expected to operate three to four days a week to meet the anticipated demand. The new clinic will comprise six rooms, in addition to a reception area and a rehabilitation space.

The Panel was given an overview of how the observation and placement provision will operate, with plans for two large clinics in Londonderry/Derry and the Ulster University medical school to support the initiative. Prior to their clinical year, students will also shadow practitioners in the new clinic building. A pre-clinic summer school will also be organised, and during their clinical year, students will undertake additional placements, with support from the University.

Regarding external observations, the Panel was informed that it is essential that observations are conducted solely in regulated environments. A list of registered chiropractors, with the Chiropractic Association of Ireland, will be provided to students and the programme handbook will outline clear rules of engagement, directing students to address any issues with the module leader or designated student support staff. If the College place students directly in a setting, a standardised quality assurance checks will be undertaken, as they are in the UK.

Meeting with students

The Panel met with two final year physiotherapy students.

The students shared positive experiences of the Ulster campus, emphasising the benefits of smaller student numbers. They appreciated the intimate and friendly

atmosphere, where they were able to build strong relationships not only with fellow physiotherapy students but also with peers from other health science disciplines. The close-knit environment contributed to a collaborative and supportive learning experience.

While the students informed the Panel that they had not frequently used student support services, they were consistently reminded of the resources available to them. Support for academic writing and general well-being was clearly signposted, making it accessible when needed. One student mentioned utilising these services for dyslexia support, noting that the funding and additional assistance provided were excellent.

The students highlighted several key facilities they regularly use, including the university's sports and gym facilities. They also took the initiative to establish a Physiotherapy Society this year, further enhancing the student experience. Both students spoke highly of the library, particularly praising the availability of electronic resources and the one-on-one sessions with librarians, which were especially helpful for dissertation support.

The students shared their experiences of interdisciplinary learning which they stated was an important aspect of the programme. Every Friday, during their first year, they participated in combined group sessions with students from various health and life sciences professions. These sessions, allowed students to work together on joint projects, fostering a multidisciplinary approach to healthcare education and encouraging teamwork across different specialisations.

Account of verbal summary given to the institution

During the final meeting with the Senior Management Team, the Panel Chair stated that its indicative recommendation to the Education Committee is to:

- recommend approval of the programme with one condition.

It was agreed that the approval report would be shared with the College for fact checking by 25 October 2024 for return to the GCC by 7 November 2024. The report will be presented to the Education Committee at its November meeting. If it is agreed that the programme meets all the Education Standards, the Committee will recommend to the Council of the GCC that the programme should be approved.

The Council of the GCC considers and decides whether to accept the recommendation of the Education Committee.

The Panel Chair concluded that, subject to approval, the Panel looks forward to returning to the campus once the clinic is established.

Recommendation to Education Committee	
1. Approve without conditions	
2. Approve with conditions	✓
3. No approval (insufficient evidence due to serious deficiencies)	

Conditions for the institution with reasons and timeframes in which they are to be met.

1. Develop the clinic ahead of the need for it for pre-clinical and clinical training. (The GCC will want to assure itself of these arrangements through a visit to the clinic).

Recommendations for the institution

1. Review whistleblowing policy to incorporate section 15 'Managing problems or concerns' of the GCC Supplementary Advice to the Education Standards 2023: Clinical Placements.
2. To review staffing and expand as need or demand require.

Commendations to the institution

The panel would like to commend:

1. The collaborative relationship developed with Ulster University.
2. Widening access to the chiropractic profession through the provision of a PT programme on the island of Ireland.
3. The development of future research collaboration with Ulster.

Signed

Rabia Ahmed

Panel Chair

Date: 24/10/24

Agenda item 12 - Annex B

Purpose

This paper informs and updates Council on the work that has been undertaken by the Education Committee during 2024.

Recommendations

The Council is asked to note the report.

Background

1. The Education Committee is currently one of the four statutory advisory committees of the GCC stipulated in the Chiropractors Act 1994. The box below shows the function of the Education Committee as stated in the Act.

The Chiropractors Act 1994 states the function of the Education Committee as:

- having the general duty of promoting high standards of education and training in chiropractic and keeping the provision made for that education and training under review. (11.1)
- providing, or arranging for the provision of, education or training where it considers it to be necessary in connection with the discharge of its general duty (11.2)
- being consulted by the Council on matters relating to education, training, examinations or tests of competence (11.3)
- giving advice to the General Council on education, training, examinations or tests of competence matters at the request of Council or proactively (11.4)
- appointing persons to visit any place / institution which is proposing a relevant course of study, holding any examination with any such course, or holding any test of competence connected with a course or for any other purpose of the Act (12)
- the Council has the power to withdraw qualifications as a result of Visitor's report or on the basis of other information acquired by the Committee (e.g. through annual monitoring) (16).

Summary of Activities

2. The Education Committee met three times in 2024 (April, July and November). Two meetings were held virtually via MS Teams and one face to face. This report summarises the work of the Committee, decisions taken, actions recommended and progress on work overseen by the Committee. The Council has received a report at each of its meetings.

Quality Assurance of Recognised Qualifications

3. During 2024 one new qualification has been recognised at Coventry University plus satellite programmes delivered by HSU at its new London campus and MCC at its Madrid and Ulster campuses.

4. From September 2024, every student studying an approved UK degree programme in chiropractic will be studying against the new Education Standards

(2023). All programmes at existing providers have been aligned with the new Education Standards.

5. The Education Committee has continued to liaise with its education providers and consider issues arising from substantive changes such as programme validation/governance changes, staffing changes and changes to modules.

6. The final annual monitoring visit to Teesside University was held in October 2024, following its first graduate cohort. The Chair of Council and Director of Development attended the graduation ceremony.

7. Discussions and meetings have continued regarding the proposed new programme in Scotland with The Scottish College of Chiropractic (SCC) and its validating partner, Buckinghamshire New University.

8. Discussions and meetings have continued with prospective new programme providers.

9. The Committee has continued to discuss and note general trends in higher education healthcare student numbers and the potential impact on chiropractic programmes.

Annual Monitoring

10. The Education Committee carried out its annual monitoring of programmes for 2022-23. Two members of the Committee and the Executive met with each institution's staff and student representatives. Key themes identified:
    - A decline in student enrolment numbers
    - The range of collaborative healthcare activities undertaken and plans for future collaboration
    - All providers reported student continuation and completion data above the Office for Students B3 metrics threshold
    - Overwhelmingly positive feedback from students.

11. The Committee approved the annual monitoring and self-assessment form for 2023-24 and providers will be asked to reflect on the key strategic challenges facing chiropractic education specifically, and their higher education institutions generally, and how these challenges may impact the delivery of chiropractic education.

12. A survey of recent graduates about their undergraduate education experience will be introduced early in the New Year to contribute to the annual monitoring process.

13. In June 2024 the GCC published its third annual education overview. The publication allows the public and profession access to a range of information and insights and shows how the GCC quality assures chiropractic education in the UK.

Work of the GCC Education Committee 2024

14. The Education Committee has been responsible for the following areas and projects:
    - Overseeing the Test of Competence (TOC)
    - The GCC's Continuing Professional Development (CPD) Scheme and audit
    - Implementation of the Education Standards
    - Review of the Code of Professional Practice and the Standards of Proficiency

Test of Competence (TOC)

15. During 2024 the Committee has continued to oversee the implementation of the TOC and considered the External Examiner's report. The report concluded that, overall, the process was operating smoothly, standards were maintained and public safety assured.

16. The report and the GCC's response are available on the GCC website.

17. The GCC has held all 2024 TOC interviews remotely and monthly to meet demand. 39 candidates sat during 2024.

18. The annual review meeting with TOC assessors was held in September 2024.

19. A recruitment exercise was held in late 2023 with new assessors and chairs being appointed and trained in early 2024. A Chairs mentoring programme has also been successfully introduced for assessors and new Chairs have been appointed.

CPD

20. For 2023/24 the focus for all registrants was on Equality, Diversity and Inclusion. This is an area that was identified by the EDI Working group and is one of the actions in the GCC's 15 point EDI action plan (Action Point 12) and is one of the overarching themes running through the new Education Standards.

21. The CPD submissions of all new registrants, together with a full review of 10% of returns, were checked and audited in autumn/winter 2024.

22. The Committee agreed that the focus for CPD for 2024-25 would be on Candour. Guidance and support materials were published in September 2024.

Implementation of the Education Standards

23. All providers have successfully reviewed and adapted their existing qualifications to meet the new Education Standards. From September 2024 all existing programmes align with the new Education Standards.

24. In March 2024 the GCC published Equality, Diversity and Inclusion Best Practice Guidance for Education Providers to support chiropractic education providers, faculty and auxiliary staff to embed equality, diversity and inclusion into teaching and learning practices in order to meet the new Education Standards.

25. Throughout 2024 GCC has been developing a Clinical Placement Strategy. The project had three main phases:
    - A scoping review of research literature and grey literature defining models for clinical placement in undergraduate healthcare education.
    - Survey / interviews and focus groups. This phase will look at gaining views of institutions, chiropractors not engaged in clinical placements and current Practice Placement Educators. Barriers and enablers will be explored throughout this phase.
    - Dissemination of findings to stakeholders through a workshop in October with a view to formulating and facilitating a strategy for the future development of clinical placements within chiropractic education.

Standards of Proficiency and Review of the Code

26. During the development of the draft Code of Professional Practice a sub group was formed from Education Committee members, who met three times to discuss the standards in the Code that are Standards of Proficiency.

Website

27. The GCC has produced a new education section of the website with more videos and blogs. There is content for students, prospective students and education providers.

Membership

28. During 2024 the Education Committee membership comprised:

Name	Member details	Dates of membership	Meetings attended 2024
Catherine Kelly	Council lay member and Chair	All year	3 of 3
Clare Allen	External lay member	All year	3 of 3
Philip Dewhurst	External registrant member	All year	3 of 3
Sally Gosling	External lay member	From May 2024	2 of 2
Sam Guillemard	Council registrant member	All year	3 of 3
Daniel Moore	External registrant member	All year	3 of 3
Aaron Porter	Council lay member	All year	3 of 3

Ralph Pottie	Council registrant member	All year	3 of 3
Keith Walker	Council registrant member	All year	3 of 3
Carol Ward	External lay member	Until 30 April 2024	1 of 1
Jessica Watts	External lay member	All year	3 of 3

Penny Bance

Director of Development

General Chiropractic Council

For noting and approval
(of Item 19)

Report from the Chair of the Audit and Risk Committee

Meeting paper for Council on 5 December 2024

Agenda Item: 13

Purpose

The purpose of this paper is for Council to receive an update from the Audit and Risk Committee.

Recommendations

Council is asked to note the report from the Chair of the Audit and Risk Committee.

Meeting of the Audit and Risk Committee (ARC) since September 2024

1. Since the last Council meeting in September 2024, the ARC met once (virtually) on 7 November 2024.

CER Report

2. The Committee received and noted the CER's report covering the period since its last meeting in May 2024.

3. The Committee noted the update on:

- Staffing matters
- Financial risks
- Regulatory reform
- Governance risks
- Business plan risks
- Complaints

The Committee welcomed and noted the report.

Management Accounts for the Period to September and October 2024

4. The Committee noted that the realised headline surplus for the period to September 2024 was £211k compared to the forecast surplus of £125k.

5. The Committee further noted the verbal update on the October 2024 management accounts from the Director of Corporate Service which confirmed that the year-end deficit forecast (as of October 2024) was expected to increase from £65k to £90k. This was largely due to mitigation actions taken by the Executive to address the temporary staffing issues within the FtP team.

6. The Committee additionally noted that the cash position remained strong, with a balance of £1m as of October 2024; and that the investment portfolio had increased in value by 1% (£232k) since last December. The total reserves were valued at £3.859m as of 31 October 2024.

7. The Committee reviewed the format of the quarterly management accounts report and the £10k variance threshold which members agreed in January 2021. Following discussions, members agreed to retain both the format of the report and the variance analysis threshold and re-affirmed their usefulness in maintaining focus without excessive detail.

8. On the HR Update report, the Committee noted that staff turnover issue in the FtP team had been addressed, and the last of the staff that was recruited would be joining the team very shortly. **The Committee noted the report.**

Strategic Risk Register October 2024

9. The Committee received the Strategic Risk Register (SRR) update report.

10. The Committee noted that strategic risk number 4 (organisational capacity) which was previously rated as severe (red) had been downgraded to moderate (amber), following the mitigation actions taken by the Executive to address the temporary staffing issues in the FtP team. **The Committee agreed the report.**

Cyclical Taxation Matters – Update

11. The Committee **noted** that the GCC's cyclical taxation matters (i.e. PAYE Settlement Agreement and corporation tax) were up-to-date. **The Committee noted the report.**

External Audit – Audit Planning Report for 2023

12. The Committee **reviewed** the external auditors' plan for the audit of the 2024 financial statements, including the proposed increase in the audit fee by approximately 9% from £21,120 in 2023 to £23,040 (including Vat).

13. The committee reviewed and endorsed the 2024 external audit planning report and proposed fee of £23,040, confirming it represented good value for money. Members commended the plan's quality and noted the benefits to the GCC of the auditors' continued engagement.

14. The Committee noted that the audit service would be put to tender before the end of the current auditors' term in 2028. The committee further noted the potential transition risks and agreed to address these during the retendering process.

The Committee agreed the 2024 audit plan proposals from the external auditors.

Information Governance Update

15. The Committee noted that all information governance matters were up to date, except for one pending data subject access request which was being responded to and concluded by the Executive. **The Committee noted the report.**

ARC Terms of Reference (Annual Review)

16. The Committee noted that the ARC Terms of Reference (ToR) were approved by Council in June 2023 and that no amendments were currently proposed by the Executive.

17. The Committee reviewed the ToR and agreed to include a section in the ToR to confirm that the Committee regularly reviewed the need for an internal audit function for the GCC while also retaining the flexibility to engage external organisations to undertake specific benchmarking exercises.

18. The Committee additionally proposed the addition to the ToR the requirement for a member of the Committee to have a formal financial/accounting qualification, either from the Council or as a co-opted member. This was to formalise the current membership composition of Committee.

19. The updated ToR (as noted above and attached as an annex) would be reported to the Council in December. **The Committee noted the report.**

Recommendation: That the Council is asked to approve the updated Terms of Reference for the Audit and Risk Committee.

Audit of Investigating Committee Decisions (Dec-23 to May-24)

20. The Committee noted that the paper would be presented to members at the next ARC meeting in March 2025. **The Committee noted the report.**

ARC Workplan 2024

21. The Committee reviewed and noted the ARC Workplan for 2024.

22. The Committee agreed that 2025 work plan should be circulated to the members by email for their review by December 2024. **The Committee noted the report.**

Strategic Risk Register - Managing the Risks Assigned to the Development Team and Impact on ARC Work

23. The Committee received a report from Penny Bance (Director of Development), outlining how the strategic risks assigned to the Development Team were being managed.

24. The Committee was informed of a registration matter which the Executive was dealing with.

25. The Committee noted the actions being taken by the Executive to address the issues raised to prevent recurrence. **The Committee noted the report.**

GCC Investments Portfolio Update – Presentation by Cazenove Capital

26. The Committee received a presentation from Jeremy Barker, GCC's Investment Manager, highlighting the following:

- Performance of the investments portfolio (currently and over time).
- Proposed review of our investment strategy – with a recommendation to increase the equities asset allocation by 5%.
- Managers' approach to the investment of GCC funds, given our ethical investment policy (i.e. not investing in companies whose principal purpose involves tobacco, alcohol and armaments).
- Potential for an increase in the current annual distributions of £120k (investment returns) from the portfolio to a higher level of annual income.
- Managers' views on the comparative performance returns of ethical and traditional investments.

27. The Committee noted that the Investment managers would present further details on the impact of the proposed strategy, focusing on income generation, ethical compliance, and risk alignment, at the December Council meeting. **The Committee noted the report.**

Any Other Business

28. There was no other business considered by the Committee.

Fergus Devitt
Chair of the Audit and Risk Committee

Annex – ARC Terms of Reference (as approved by Council in Jun-23 and reviewed* by ARC in Nov-24)
** the tracked changes are in red*

*

Audit & Risk Committee's Terms of Reference

Duties

The Audit & Risk Committee (ARC) is a non-statutory advisory committee of the General Chiropractic Council, working within the policy and priorities agreed by the Council. The Committee does have some delegated powers, and these are highlighted at point 8.

The Committee is required to carry out the following duties for Council.

1 External Audit

The Committee shall oversee the relationship with the external auditor including, but not limited to:

1.1 Considering and making recommendations to the Council in relation to the appointment, re-appointment and removal of the GCC's external auditors. The Committee shall oversee the selection process for new external auditors and, if an auditor resigns, the Committee shall investigate the issues leading to this.

1.2 Approval of the external auditor's remuneration, whether fees for audit or non-audit services, and ensuring that the level of fees is appropriate to enable an adequate audit to be conducted.

1.3 Approval and sign-off of the external auditor's engagement letter and the scope of the audit.

1.4 Assessing annually the external auditor's independence and objectivity taking into account relevant professional and regulatory requirements and the relationship with the auditor as a whole, including the provision of any non-audit services.

1.5 Satisfying itself that there are no relationships (such as family, employment, investment, financial or business) between the external auditor and the GCC.

1.6 Assessing annually the external auditor's qualifications, expertise and resources and the effectiveness of the audit process which shall include a report from the external auditor on their own internal quality procedures.

1.7 Undertaking an annual review of the effectiveness of external audit.

1.8 Monitoring the external auditor's compliance with relevant ethical and professional guidance on the rotation of audit partners and other related requirements.

1.9 Meeting at least once a year with the external auditor, including once at the planning stage before the audit and once after the audit at the

reporting stage. The Committee shall meet the external auditor at least once a year, without management being present, to discuss their remit and any issues arising from the audit.

1.10 Reviewing and approving the annual audit plan and ensuring that it is consistent with the scope of the audit engagement.

1.11 Reviewing the findings of the audit with the external auditor. This shall include but not be limited to:

- a discussion of any major issues which arose during the audit,
- any accounting and audit judgments, and
- levels of errors identified during the audit.

1.12 Reviewing any representation letter(s) requested by the external auditor before recommending this for signing by Council.

1.13 Review the management letter of the external auditor, any material queries raised by the auditor to management of the GCC in respect of the accounting records, financial accounts or systems of control and the response of management of the Company.

1.14 Ensure that the management provide a timely response to the issues raised in the management letter of the external auditor.

1.15 Recommend to Council the Annual Accounts and an action plan to deal with any issues raised in the management letter after considering GCC management representations, if applicable.

2 .Internal Audit

The Committee shall:

2.1 Monitor and review the need for an ~~effectiveness of any~~ internal audit function for the GCC while retaining the flexibility to engage external organisations to undertake benchmarking exercises as required.

2.2 Review promptly all reports to the Audit & Risk Committee on the GCC from any internal auditors.

2.3 Where an internal audit function exists, to ensure co-ordination between the internal and external auditors.

2.4 Review and monitor management's responsiveness to the findings and recommendations of any internal audit report.

3 Whistleblowing

3.1 The Committee shall review the arrangements for employees to raise concerns, in confidence, about possible wrongdoing in financial reporting or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

3.2 The Committee's Chair will be responsible as required for receiving and investigating all concerns raised under the whistleblowing procedure.

3.3 In investigating concerns raised, the Committee's Chair will follow the procedures as described in the GCC's published Whistleblowing Policy.

4 Internal Controls and Risk Management Systems

The Committee shall:

4.1 Oversee the principal risks faced by the GCC, the extent of the principal risks it is willing to take to achieve its strategic objectives, and how the risks are being mitigated.
4.2 Keep under review the effectiveness of internal controls for ensuring compliance with the regulatory environment within which the GCC operates.
4.3 Review and approve the statements to be included in the Annual Report concerning governance, internal controls and risk management.
4.4 Review the GCC's Strategic Risk Register, Assurance Map and report to Council any significant changes to the Risk Register.
4.5 Ensure that the findings from external and internal audits inform the development of the GCC's Strategic Plan.
4.6 Keep under review and advise Council about the effectiveness of the assurance systems in place within the organisation for the identification and management of risks.
4.7 The Committee will present the Strategic Risk Register to Council at least twice (i.e. June and December) a year.
4.8 At every meeting of Council, the Committee will report to Council every risk scoring over 15 on the risk register.
4.9 Oversee procurement of contracts in line with expenditure delegations to assure Council that contacts were awarded following relevant policies and due process.

5 Financial Reporting

The Committee shall:

5.1 Monitor the integrity of the financial statements of the GCC, reviewing significant financial reporting issues and judgments which they contain.
5.2 Review the appropriateness, consistency of and any changes to accounting policies.
5.3 Review the methods used to account for significant or unusual transactions where different approaches are possible.
5.4 Review whether the GCC has followed appropriate accounting standards and made appropriate estimates and judgments, taking into account the views of the external auditor.
5.5 Review the clarity of disclosure in the financial reports and the context in which statements are made.
5.6 Review all material information presented with the financial statements and the Annual report, if applicable.

6 Reporting Responsibilities

6.1 The Committee Chairman shall report formally to the Council on the Committee's proceedings after each meeting on all matters within its duties and responsibilities, including financial reporting.

6.2 The Committee shall make whatever recommendations to the Council it deems appropriate on any area within its remit where action or improvement is needed.

6.3 An annual report of the Committee's activities is to be presented to Council each March''. The Committee is to produce and include a governance statement in the audited annual report and accounts.

7 Other Matters

7.1 Ensure that its members take individual responsibility for identifying training appropriate to their needs and raising these requirements with the Chair of Council.

7.2 Be provided with an induction programme for new Committee members.

7.3 Consider issues in relation to succession planning for members of the Committee.

7.4 Give due consideration to laws and regulations.

7.5 At least once every two years, review its own performance, constitution and terms of reference to ensure it is operating effectively and report the results of this review to the Council for approval.

7.6 Oversee any investigation of activities which are within the Committee's terms of reference.

7.7 Work and liaise as necessary with all other committees of Council ensuring interaction between committees and with the Council is reviewed regularly, taking account of the impact of risk management and internal controls being delegated to different committees.

8 Authority

8.1 The Committee has delegated authority for:

- agreeing the planned activity of external audit.
- proposals for tendering for External Audit services or for purchase of non-audit services from contractors who provide audit services.
- reviewing the GCC's Strategic Risk Register, Assurance Map and reporting to Council any significant changes to the Risk Register.
- the approval of the auditor's remuneration whether the fees are for audit or non-audit services.

9 Membership

9.1 The Chair and members of the Audit & Risk Committee including the independent member shall be appointed by the Chair of the GCC and such appointments will be reported by the Chair to Council.

9.2 Appointments to the Committee shall be for a period of three years from the date of appointment, or for the length of term remaining for any particular Council member appointed if less than three years.

9.3 Members are eligible for re-appointment and there is no maximum term of membership.

9.4 The Committee's membership shall be three members of Council including the Committee's chairman and one independent member who is a qualified accountant drawn from the Council or as a co-opted member.

9.5 The Chairman of the Council shall not be a member of the Committee.

9.6 The external auditors shall be invited to attend meetings of the Committee at least once a year. The Committee may request other staff or professional to attend the meeting, if required, to aid in discharging the duties of the Committee.

10 Audit & Risk Committee Quorum and Meetings

10.1 The Director of Corporate Services or their nominee shall act as the Secretary of the Committee.

10.2 The quorum necessary for the transaction of business shall be 3 members, one of whom must be the independent member.

10.3 If the Committee's Chair is unable to attend a meeting, the members present will select a Chair for that meeting.

10.4 In the absence of the external independent member, the Committee would co-opt an external member to cover any such absence.

11 Frequency of Meetings

11.1 The Committee shall meet at least three times a year at appropriate times in the reporting and audit cycle, and otherwise as required. Meetings will be planned in advance for each reporting year.

12 Notice of Meetings – exceptional and regular

12.1 Exceptional meetings of the Committee shall be convened by the Secretary of the Committee at the request of any of its members or at the request of external or internal auditors if they consider it necessary.

12.2 Unless otherwise agreed, notice of each regular meeting of the Committee confirming the venue, time and date together with an agenda of items to be discussed shall be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

13 Minutes of Meetings

13.1 The Secretary shall minute the proceedings and resolutions of all meetings of the Committee, including recording the names of those present and in attendance.

13.2 The Secretary shall record any conflicts of interest divulged at the meeting.

13.3 Minutes of Committee meetings shall be circulated promptly to all members of the Committee and, once agreed, to all members of the Council.

14 Dissolution

14.1 Dissolution or changes to the terms of reference of the Audit & Risk Committee shall be at the discretion of the General Chiropractic Council.

Version Control				
Version No.	**Key Changes**	**Agreed By/date**	**Issue Date**	**Date of Next Review**
1.00	Redrafted the TOR for the Audit Committee. Changes include changing the name of the Audit Committee (AC) to Audit and Risk Committee (ARC), and enhanced risk management responsibilities for the Committee.	The Audit and Risk Committee (ARC) agreed to recommend the TOR for the Committee to Council.	31/05/18	
1.01	No changes	Council agreed the TOR for the ARC	27/06/18	
2.00	Key changes made: insertion of a new Section 4.1 and change from every meeting to at least once a year in Section 4.7	Presented for a 3-year review by the ARC	09/11/21	
3.00	Updated sections: • 1.9, • 4.4, • 4.7, • 4.9, • 6.3, • 7.5, • 7.7, • 8.1, • 9.4 and • 9.6	Reviewed and agreed by the ARC	23/05/23	May 2024
4.00	Annual review of the ARC TOR – changes to sections 2.2.1 and 9.4	November 2024	07/11/24	Nov-25

General Chiropractic Council

For noting and approval
(Items 6, 8 and 12)

Report from the Chair of the Remuneration and Human Resources Committee

Meeting paper for Council on 5 December 2024

Agenda Item: 14

Purpose

This paper provides an update to Council from the Chair of the Remuneration and Human Resources Committee.

Recommendation

Council is asked to **note** the report.

Committee Meetings

1. The Committee met once, on 19 November 2024, since the last Council meeting.

CER Operational Report

2. The CER provided an update on staffing, Case Management System (CMS) for the Fitness to Practise team, organisational review exercise and the HR policies reviewed in the preceding 12 months.

3. The Committee members agreed to review the HR policies with final comments to the Executive within a three-week deadline (i.e.10/12/2024). **The Committee noted the report.**

Pay Award Proposal

4. The Committee considered a detailed report from the Executive concerning proposed pay awards for the 2025 calendar year. The report highlighted the forecast inflationary and economic indices for 2025, the planned awards by other healthcare regulators for 2025 and the consumer price index with housing (CPIH) report as of September 2024.

5. Following discussions, the Committee agreed to recommend a 3% pay award to Council for the 2025 calendar/financial year. The award would be subject to the availability of funds in the 2025 Budget which would be reviewed by Council in December 2024.

6. Members also considered and noted the other proposals as set out in the paper. **That the e Committee agreed to recommend a 3% pay award to Council, subject to availability of funds in the 2025 Budget which would be reviewed by Council in December 2024**

Recommendation: That the Council considers the approval of a 3% pay award to the GCC staff, subject to availability of funds in the 2025 Budget.

Review of GCC Partners' Service Contracts - Update

7. The Committee received an update on the review of the partners' service contract, including the advice from the solicitors and tax advisers on the employment status of our partners.

8. The members considered the report and noted the advice and proposals set out in the paper. **The Committee noted the report.**

Recommendation: That the Council notes the progress made to-date on the review of the partners' service contract.

Council Associate Programme – Update

9. The Committee received an update on the Council Associate Programme.

10. Following discussions, members agreed to recommend to Council the appointment of two Associate members.

11. The Committee noted that the appointment decision aligned with Council's efforts to improve diversity on the board to benefit from diverse perspectives.

12. The Committee further noted the effectiveness of the selection process. **The Committee noted the report.**

Recommendation: That the Council approves the appointment of two Council Associate members.

Succession plan

13. The Committee noted the successful recruitment of an Independent Panel Member following an open selection process in November 2024. **The Committee noted the report.**

Updated GCC Operating policy

14. The Committee received the updated Expenses Policy and Health and Safety Policy.

15. The Committee noted that the key highlights of the policies included the increase in accommodation rates.

16. Following discussion, members agreed to include a clarification in the expense policy to explicitly state that alcohol was not allowable for reimbursement.

The Committee approved the operating policies subject to the changes agreed above.

Remuneration and HR Committee Work Programme

The Committee noted the Committee's workplan & meeting dates for 2025.

Next Meeting

17. The next meeting will take place on 10 April 2025 (Virtually).

Recommendation

Council is asked to **note** the report.

Keith Richards
Chair of the Remuneration and HR Committee

Council – Work Programme

For agreement

Meeting paper for Council on 05 December 2024

Agenda Item: 15

Purpose

This table outlines the key activities that will be coming to Council meetings for the remainder of 2024 and meetings of 2025. This enables Council to have sight of annual standing items as well as strategic items which will require Council's approval, discussion or noting.

Recommendation

That Council is asked to agree the work programme and 2025 Council meeting dates.

Council Work Programme – 2024 and 2025

Strategic Items for discussion or approval

Item	December 2024	March 2025	June 2025	September 2025	December 2025
Outline Business Plan	To **approve** – final draft			To **discuss** – first draft BP for 2026	To **approve** – final draft
Periodic Management Accounts	To **note**	To **note**	To **note**	To **note**	To **note**
Financial Forecast			To **approve**		
Draft Budget 2025 and 2026	To **approve**				To **approve**
Strategic Risk Register	To **approve**		To **approve**		To **approve**
Regulatory Reform	To **note** - update (if any)	To **note** - update (if any)	To **note** - update (if any)	To **note** - update (if any)	To **note** - update (if any)

Performance Reporting and Review

Item	December 2024	March 2025	June 2025	September 2025	December 2025
Business Plan Update Report	To **note**	To **note**	To **note**	To **note**	To **note**
Fitness to Practise Performance Update	To **note**	To **note**	To **note**	To **note**	To **note**
Professional Standards Authority Review				To **note** - report on the outcome review	
Committee Chair Update Report – Education	To **note**		To **note**	To **note**	To **note**
Committee Chair Update Report – Audit and Risk	To **note**	To **note**	To **note**		To **note**
Committee Chair Update Report – Remuneration and HR	To **note**		To **note**	To **note**	To **note**
Operational Update (private session)	To **note**	To **note**	To **note**	To **note**	To **note**
Code of Professional Practice	To **note**	To n**ote**	To **note**	To **note**	To **note**

Annual Reporting

Item	December 2024	March 2025	June 2025	September 2025	December 2025
GCC Annual Report and Accounts 2024		To approve			
Annual Report – IC		To **note**			
Annual Report – PCC		To **note**			
Annual Report – EC	To **note**				
Annual Report – Registration Annual Report – Audit and Risk		To **note**			

[Confirmed] Council Meeting Dates 2025

Meeting	Date	Format
Development Day	Tuesday 18 March	In-person
First Meeting	Wednesday 19 March	In-person
Second Meeting	Wednesday 18 June	Teams
Third Meeting	Wednesday 1 October	In-person
Fourth Meeting	Wednesday 3 December	Teams