A meeting of the General Chiropractic Council

30 September 2026 at 10:00 – 15.05

Park House, 186 Kennington Park Road, London SE11 4BT

Agenda

	Item	Action	Presenter	Time
1.	**Welcome, Apologies and Declarations of Interest**		Chair	10.00
2.	**A. Council minutes of the meeting held on 17 June 2026** **B. Matters arising from the meeting**	To approve	Chair	10.05
3.	**Report of the Chair of Council**	To note	Chair	10.10
4.	**Report of the Chief Executive and Registrar**	To note	CER	10.20
5.	**Executive report of performance - Dashboard and narrative**	To approve	Executive team	
6.	**Professional Standards Authority Performance Review 2025/26 - report**	To note	CER	10.50
7.	**Guidance on sanctions**	To approve	Director of FtP	11.10
	Break			**11.30**
8.	**Update Report from the Chairs of Committees** **A. Education Committee** **Approval of Scotland College of Chiropractic Programme**	To note and approve	Chair, EC	11.45
	B. Remuneration and HR Committee	To note	Chair	12.05
9.	**Mediation pilot scheme**	To note	Director of FtP	12.15
	Lunch – for attendees and observers served in the collaboration area			**12.45**
10.	**Safeguarding and criminal checks**	To note	Registration Manager	14.00
11.	**Protection of Title review update**	To note	Policy Officer	14.30
12.	**Any Other Business**		Chair	15.00

Close of meeting: 15.05 followed by short private meeting of the Council at 15.15 – 15.45

Date of next meeting: 9 December 2026

[Unconfirmed] Minutes of the Public Session meeting of the General Chiropractic Council 17 June 2026 at 09:30am by videoconference

Members present	Jonathan McShane (Chair of Council) Alistair Brown Annie Newsam Catherine Kelly Elisabeth Angier Fiona Hutchinson	Fergus Devitt Jennie Adams Keith Walker Paul Allison
Apologies	Apologies were received from Aaron Porter and Samuel Guillemard	
In attendance	Nick Jones, Chief Executive and Registrar (CER) Hannah Fellows, Director of Fitness to Practise (D, FTP) Rejitha Jeyasingham, Finance and Contracts Officer (recorder)	Joe Omorodion, Director of Corporate Services, DCS (minutes) Penny Bance, Director of Development (D, Development) Daniel Sullivan, Council Associate Sumaya Ahmed, Council Associate (first half hour only)
Observers	Siobhan Carson (Senior Scrutiny Officer at the PSA) and Abdul-Rahman Lawal (PSA, for L&D) David Collins, Partner, Capsticks – (Kate Steel sends her apologies) Jennie Jones and Sue Clark, Nockolds – for mediation part	GCC: Henry Omokhamhetha, Information Governance Lead Aaron Grell, Registrations Manager Claire Bond, FtP Operational Manager Maria Abagnale, FtP Senior Investigator Karol Robert, FtP Protection of Title Caseworker & Committee Coordinator Emma Braimah, FtP Investigator Khizra Saeed, FtP

1.	**Welcome, apologies and declarations of interest** The Chair opened the meeting and confirmed that the meeting was being recorded solely for the purpose of preparing the minutes. The Chair noted that, whilst recordings of meetings are not published, transcripts of meetings may be disclosable. Apologies were received from two members, and one member confirmed that they would need to leave early.

	The Chair welcomed observers from the Professional Standards Authority (PSA), Capsticks and Nockolds. Several members of the GCC staff team were also in attendance for relevant items. No new declarations of interest were reported. Council **noted** the update.
2.	**Council Minutes of 18 March 2026 and Matters Arising** Council reviewed the minutes of the meeting held on 18 March 2026 and agreed that they were an accurate record. A matter arising relating to the cyber-security risk rating was noted for discussion under Item 7. Council **approved** the minutes.
3.	**Operational Update** The Chair reported on developments relating to the draft GCC Order and confirmed that the Executive continued to monitor progress closely. The Chair highlighted the need to begin planning for Council succession. Although 2026 had been a quiet year for appointments, several retirements were expected in 2027. Council was invited to share views on whether to pursue reappointments or open recruitment, recognising the balance between continuity and bringing in new perspectives. The Chair confirmed that an Appointments Committee would be set up later in the year to oversee the recruitment process. The Chair also noted that the terms of the two Council Associates were approaching their conclusion. The Remuneration and HR Committee would prepare an evaluation report on the effectiveness of the Council Associate roles, including feedback from the Associates and Council members, to inform future decisions about the scheme. Council **noted** the report.
4.	**Operational Update** The CER provided an update on operational and policy matters. The CER confirmed that the GCC response to the draft GMC Order would be discussed in the private session before being finalised and published. The CER reported on the joint regulatory work concerning the use of AI in healthcare, including participation in MHRA-led workshops on professional liability. The CER also outlined the expectations arising from Lord Mann's report on antisemitism and racism and confirmed that coordinated work was underway across regulators.

	In response to a question about progress on appointments at the National Centre for Chiropractic Research (NCCR), the CER reported that there was nothing material to report at this stage. The CER noted that workforce development discussions within the profession remained at an early stage and that the GCC continued to play a convening role. Council **noted** the report.
5A.	**Fitness to Practise (FtP) Performance Update** The D, FtP presented the Q1 performance update. The Director reported that the FtP Directorate had stabilised following recent staffing changes and that all posts were now permanently filled. The Case Management System (CMS) was fully embedded, and there was no backlog of new enquiries. The Director confirmed that 16 new Section 20 complaints were received in Q1. Although the number of open cases had increased, the median age of cases had reduced from 33 to 29 weeks. The Director noted that older and more complex cases continued to be progressed and that this may affect the median age figures in future quarters. The Director provided an update on the development of the mediation pilot service. In response to questions, the Director explained that the mediation provider already worked with other healthcare regulators and understood the parameters of pre-referral mediation. Section 32 matters could be considered for mediation where appropriate, provided that any risk to the public was escalated to the GCC. The Director confirmed that a comprehensive paper on the mediation pilot would be presented to Council in the near future. In response to a question about cyber-security resilience in relation to FtP work, the Director confirmed that FtP operations could continue without the CMS in the event of a cyber-attack, although productivity and reporting would be slower. Investigations and hearings could continue using spreadsheets and manual processes, and the GCC's cyber partner could support rapid recovery. Members noted the improved information provided on the GCC website to signpost queries more effectively. Council discussed the communication of the mediation pilot to the public and registrants, and the approach to evaluating the pilot. **Action 1:** The D, FtP will finalise the eligibility criteria for the mediation pilot, including safeguards for Section 32 matters. **Action 2:** The D, FtP will develop the evaluation framework for the mediation pilot. **Action 3:** The D, FtP will report on the outcome of the mediation pilot to Council in December 2026. Council **noted** the update.

5B.	**Finance Update – Management Accounts to May 2026** The DCS presented the management accounts to May 2026. The Director confirmed that the GCC had achieved its surplus target for each of the first five months of the year and that reserves had increased to £4.4m, largely due to investment performance. The Director reported that the forecast business-as-usual (BAU) surplus had been revised to £31k due to emerging cost pressures, particularly in relation to hearings. The DCS also outlined short-term financial risks and the scenario planning undertaken to support financial resilience. The Director further highlighted the current strength of the balance sheet – result of strong investment performance. A member queried what constituted BAU and non-BAU expenditure, and it was noted that point would be raised in the private session later in the day. Council **noted** the report.
5C.	**Business Plan 2026 Update** The D, Development provided an update on progress against the 2026 Business Plan. The Director confirmed that the nine projects were on track. Council noted the detailed and transparent format of the report and asked whether similar reporting could be expected in future. The Director explained that the Executive was in a period of transition regarding how its work was reported to Council and that a separate agenda item later in the day would address this. The Director reported that work on the CPD review was underway with external consultants and that the Education Committee was providing oversight. Council **noted** the update.
6.	**GCC Guidance on Sanctions Review** The D, FtP presented the updated draft of the GCC Guidance on Sanctions. The Director explained that the revised guidance provided clearer separation between findings, Unacceptable Professional Conduct (UPC), sanction stages, and improved usability for committees. Council discussed the need to ensure alignment with the GCC Order, the Lord Mann report and equality considerations. Members also raised points relating to the EQIA, references within the guidance to sexual misconduct, convictions and minor drafting corrections. **Action 4:** The D, FtP will incorporate the drafting comments raised by Council in the consultation draft.

	Action 5: Following consultation, the D, FtP will present the revised sanctions guidance to Council for approval, in September 2026. Council **approved** the guidance for consultation.
7.	**Strategic Risk Register** The CER presented the updated Strategic Risk Register (SRR). The CER reported that the Audit and Risk Committee (ARC) had carefully reviewed the rating of SR5 (cyber security) and recommended that the rating be increased from minor (green) to severe (red). The CER noted that the ARC had emphasised that the increased rating reflected the external cyber-threat environment and did not indicate any inadequacy in the GCC's current mitigations. After a detailed discussion, Council agreed the recommendation from the ARC that the rating should be maintained at severe (red). Council **approved** the Strategic Risk Register.
8A.	**Audit and Risk Committee Chair's Update** Jennie Adams, who acted as Chair for the Audit and Risk Committee meeting held on 20 May 2026, reported on the Committee's recent work. The Acting Chair highlighted the 12 financial and corporate policies due for approval later in the afternoon, the Executive's management of organisational capacity, and the updated risk assurance map reviewed by the Committee at its last meeting. The Acting Chair read out the annual risk assurance statement, which the Committee had reviewed and agreed at its May 2026 meeting. The Committee recommended that Council agree that the risks and mitigations in place at the GCC continued to be effective and adequate. Council **agreed** the 2025/26 (May 2025 – April 2026) annual risk assurance statement. Council **noted** the update.
8B.	**Education Committee Chair's Update** The Chair of the Education Committee reported that Teesside University would close its chiropractic programme due to student recruitment challenges. The remaining students were being supported through enhanced monitoring. The Chair of the Education Committee also noted that AI was a significant theme across education providers and that the CPD focus for the forthcoming year would be professional boundaries. Finally, that the application by Scotland College of Chiropractic for an approved chiropractic programme was progressing to 'Stage 4 - approval.' Council **noted** the update.

8C.	**Remuneration and HR Committee Chair's Update** The Chair of the Remuneration and HR Committee reported that the HR strategy had been strengthened to align staff responsibilities with organisational objectives. Work continued on the remuneration methodology for 2027, and the Committee was preparing for discussions on reappointments. Council **noted** the update.
9.	**Council Work Programme and 2027 Meeting Dates** The Chair presented the proposed meeting dates for 2027. The Chair confirmed that Committee Chairs would be consulted on the sequencing of committee meeting cycles. Council agreed to continue with the current pattern of in-person meetings in March and September and remote meetings in June and December. **Action 6:** The Chair would coordinate with Committee Chairs on the sequencing of committee meeting cycles for 2027. Council **approved** the meeting dates.
10.	**Any Other Business** No additional business was raised. Observers were invited to comment, and no comments were offered. The Chair thanked members and staff for actively engaging with the matters discussed at the meeting. The Chair extended his appreciation to the observers for their attendance at the meeting. The public session closed at 11:20am. The private session was scheduled to begin at 13:10pm. Council **noted** the conclusion of business. **Date of next meeting** **30 September 2026 – In-person at the GCC offices**

General Chiropractic Council

For noting

Agenda Item: 02b Matters arising

Presenter: Chair

Summary: There are no outstanding actions from meetings held prior to June 2026. There were six actions arising from the Council meeting held on 17 June 2026. Four actions are complete, one has been revised and one remains outstanding.

Matters Arising from 17 June 2026 Meeting			
Item	**Actions**	**Led by**	**Update**
CO260617-05a	**Fitness to Practise (FtP) Performance Update**		
	Action 1: Finalise the eligibility criteria for the mediation pilot, including safeguards for Section 32 matters.	Director of Fitness to Practise (FtP)	Completed. See agenda item 9
	Action 2: Develop the evaluation framework for the mediation pilot.	Director of FtP	Completed. See agenda item 9
	Action 3: To report on the outcome of the mediation pilot to Council in December 2026.	Director of FtP	Proposed evaluation now proposed due March 2027
CO260617-06	**GCC Guidance on Sanctions Review**		
	Action 4: Incorporate the drafting comments raised by Council in the consultation draft.	Director of FTP	Completed. See agenda item 7, for approval
	Action 5: Following consultation, present the revised sanctions guidance to Council for approval, in September 2026.	Director of FTP	Completed. See agenda item 7, for approval
CO260617-09	**Council Work Programme and 2027 Meeting Dates** **Action 6:** The Chair would coordinate with Committee Chairs on the sequencing of committee meeting cycles for 2027.	CER	Action required

General Chiropractic Council

For noting

Chair's report

Recommendations

Council is asked to note this report with questions invited.

Introduction

1. Members are welcomed to this in-person meeting of Council. The September meeting provides an opportunity to take stock of delivery during 2026, consider the organisation's current performance and risks, and look ahead to the priorities and resources required for 2027.

2. The agenda reflects those purposes. Council will be asked to approve or note Council's sanctions guidance policy following consultation over the summer, the Professional Standards Authority performance review of the GCC, the new performance dashboard and accompanying narrative progress against the 2026 Business Plan, and the emerging shape of the 2027 plan. It will also consider important regulatory and policy matters, including professional boundaries, the mediation pilot, safeguarding and criminal checks, and latest developments in our work to update our protection of title policy.

Meeting of Committee Chairs

3. In July, I met with the Chairs of the Audit and Risk, Remuneration and HR, and Education Committees, together with the Chief Executive and Registrar. This was the first of a proposed series of informal discussions between Council meetings, intended to provide space for strategic reflection across committee boundaries.

4. The discussion ranged across the longer-term shape and resilience of the organisation, opportunities for closer collaboration with other regulators, the future of the profession, organisational capacity and succession, and the continuing importance of fitness to practise improvement. The mediation pilot was recognised as a significant and constructive development, while acknowledging that improvement in fitness to practise outcomes will require persistence and a willingness to manage risk carefully.

Council and Associate Member recruitment

5. Work on Council succession and recruitment is progressing. I am grateful to those who have supported the selection and evaluation activity to date. Feedback from the current Associate Members has also provided useful learning about recruitment, induction and how the role can make the strongest contribution.

6. As appointments and reappointments are considered, the starting point remains that reappointment is not automatic. Decisions must continue to be based on the needs of Council, the skills and contribution required for the next period, satisfactory performance and the proper appointments process.

Professional Standards Authority

7. The report on the Professional Standards Authority's review of our performance is at agenda item 6, and we will discuss it then. It is right that the findings are considered carefully and in context. The report provides important external assurance, while also identifying matters on which further improvement and evidence will be required. I am pleased that the review process has recognised progress, but Council should remain focused on the substance of the remaining concerns and the organisation's response.

8. The Chair of the PSA has written to me regarding Standard 15 and Fitness to Practise timeliness. The letter reflects the PSA's concern that this Standard has not been met for a third consecutive year, whilst also recognising the improvements made by the GCC, the robustness of our investigations, the progress achieved at earlier stages of the process, and the fact that the PSA did not consider escalation to the Secretary of State to be necessary at this time. The PSA notes that Council is sighted on the issue and the actions being taken to address it. I welcome that recognition, while also acknowledging the importance of the message. Council takes the finding seriously and is clear that demonstrable improvement in end-to-end timeliness remains a priority. We will continue to oversee the improvement programme closely, seeking assurance that progress is being made while maintaining the quality, fairness and public protection outcomes that the PSA's review also recognised.

Jonathan McShane

Chair of Council

General Chiropractic Council

For noting

Chief Executive & Registrar's report

Purpose

This report provides an overview of significant developments since Council met in June. We introduce a new way of providing performance information, presented through the dashboard and narrative from the executive leadership team. This report supports that - on context, emerging issues and matters that cut across those reports.

Recommendations

Council is asked to note this report with questions invited.

Performance dashboard

1. The revised dashboard (see next agenda item) is intended to support a more strategic discussion of performance, focused on whether we are achieving the outcomes in the 2026–30 Strategy rather than reproducing operational reports. It has been refined following Council's discussion in June and subsequent review.

2. The dashboard should be read with its short narrative. The figures alone cannot explain every movement or provide all the assurance Council may need. The narrative identifies the principal messages, exceptions and areas requiring attention, while the supporting papers retain the detail needed for scrutiny. This remains an evolving approach and Council's feedback will be important.

Lord Mann review

3. Work continues in response to the recommendations of the Lord Mann review on tackling antisemitism and other forms of racism in healthcare and professional regulation. Our approach is being developed across policy, education, employment and fitness to practise, with an emphasis on practical implementation rather than a stand-alone response.

4. Current work in our action plan includes identifying suitable training for staff and decision makers and considering how expectations should be reflected in guidance, decision-making and organisational practice. In addition to collaborating with other regulators, the PSA and DHSC we are collaborating with

the General Osteopathic Council (GOsC) on meeting the recommendations, sharing idea and resources and we welcome this joint working.

Joint Statement of Intent on the safe, effective and ethical use of artificial intelligence (AI) in health and care.

5. The National Commission into the Regulation of AI in Healthcare reported on 10 September 2026 and committed regulators to working together to develop a consistent, proportionate and trusted approach to regulating AI. The collaboration recognises both the significant opportunities AI presents for patients, the public and professionals, and the importance of maintaining public confidence through appropriate safeguards and clear regulatory expectations. Subsequently, we joined all UK health and social care professional regulators and the Accredited Registers Collaborative in publishing a joint Statement of Intent on the safe, effective and ethical use of artificial intelligence (AI) in health and care.

6. The GCC played an active role in the development of the statement and the accompanying programme of work. As a first step, participating organisations are developing a set of high-level principles to guide how AI is used by health and care professionals across the UK. This represents an important example of regulators working collectively to address an emerging issue before problems arise, providing greater clarity for professionals while promoting consistency across the regulatory landscape.

7. In support of the launch, I noted that "the GCC welcomes a coordinated approach across professional regulation to support the safe, effective and ethical use of AI in health and care" and that AI has "real potential to benefit patients, the public and professionals, when used responsibly, transparently, and in ways that maintain public trust." I also emphasised that the role of regulators is to help make this possible by providing clarity for professionals, supporting innovation, and ensuring that professional standards and patient safety remain at the heart of care. Overall, I believe this work demonstrates that the GCC is well positioned on this agenda: embracing the opportunities presented by technological innovation while remaining firmly focused on our core purpose of protecting patients and the public.

PSA guidance on sexual misconduct

8. The Professional Standards Authority (PSA) recently published a report on improving the handling of sexual misconduct cases in fitness to practise. Whilst it is not formal guidance, it is likely to be influential across professional regulation and provides a clear indication of emerging expectations of regulators in this area. The report emphasises trauma-informed processes, support for witnesses, robust decision-making and sanctions, and ensuring that concerns about sexual misconduct are understood and addressed as matters of public protection rather than solely individual misconduct.

9. The report is timely. Council is separately today considering updated sanctions guidance, arrangements around safeguarding - and this year published professional boundaries guidance and toolkit all of which touch directly on these themes. The PSA report also resonates with wider work across the sector on the experience of witnesses, communication, and the handling of vulnerable participants in fitness to practise processes.

10. Our initial assessment is that much of the direction of travel is already reflected in our work or under way, including improvements to sanctions guidance specifying the seriousness of cases involving sexual misconduct, consideration of trauma-informed practice including roll out of more training for investigation staff, witness support and communication. We are also relaunching our quality review measures for completed cases with a focus on themes. We envisage that this quality review mechanism will allow us to identify additional specific learning.

Refresh of the public register

11. Earlier this month, we launched our new online Register search, making it easier for patients, members of the public, employers and other organisations to check whether a chiropractor is registered with the GCC.

12. The new search acknowledges that many patients use the register as a directory – so it can be used to search for a chiropractor near a location (showing matches on a map) - as well as search using details such as a chiropractor's surname, or registration number. The search also better supports "fuzzy matching", so users can find the right person even if they do not enter a full registered name.

13. The new results page gives clearer information about a chiropractor's registration status. This includes whether someone is practising, non-practising, suspended, removed from the Register, subject to an interim suspension, subject to conditions of practice, or has received an admonishment. Where relevant, the search includes explanatory text to help patients and the public understand what those statuses or restrictions mean.

14. By default, the search focuses on chiropractors who are currently registered and practising. Users can choose to include non-practising, suspended or removed chiropractors in their search results if they need to check a wider range of registration statuses.

Business planning for 2027

15. Planning for 2027 is under way. The 2026–30 Strategy was deliberately designed as a multi-year programme, and the emerging plan is therefore one of continuity rather than significant change in direction. The emphasis will be on completing and embedding work already begun, sustaining core regulatory performance, and sequencing new development activity realistically.

16. Our outline plan identifies the main priorities and dependencies. Further work will test affordability, capacity and delivery timing before the full Business Plan and budget are presented to Council in December.

Case management system – realising the benefits

17. As part of our commitment to evaluating the impact of major organisational investments, I have annexed a benefits realisation review of the Fitness to Practise Case Management System (CMS), prepared by Hannah Fellows. The review concludes that the system has delivered benefits anticipated in the original business case approved by Council in 2024, including improved case progression, stronger business continuity and resilience, reduced reliance on manual processes, enhanced collaboration and information security, and the ability to absorb higher caseloads without increasing staffing levels. Reporting and management information have also improved, although further development is required to realise the full analytical capability of the system. The review recognises that some benefits have been fully realised, while others remain dependent on further optimisation and system maturity.

18. I hope Council find the review useful as an example of how we seek to assess not simply whether projects have been delivered, but whether they are generating the organisational value and outcomes originally envisaged.

Strategic risks

19. The strategic risk position remains actively managed. No new strategic risks are proposed in this report, but the following issues merit emphasis.

- Capacity. The risk has reduced as the organisation now has a full staff complement and greater stability in key teams. Capacity is nevertheless finite, and the combined demands of core delivery, improvement activity and development work require disciplined prioritisation.
- Finance. The financial position remains stable and is being managed within the financial strategy. Cost pressures, particularly those linked to fitness to practise activity, continue to require close monitoring.
- Cyber security. Cyber remains a high underlying risk because of the external threat environment. Controls, training and resilience arrangements reduce the likelihood and impact of an incident, but cannot remove the risk.
- Fitness to practise and regulatory performance. Improvement activity is established, but changes in headline outcomes will take time because of the age and complexity of parts of the caseload. The PSA review reinforces the need to maintain focus and evidence sustained improvement.
- Information governance and digital resilience. Discovery work is under way to shape a digital and information governance strategy for delivery from 2027. This is intended to bring together systems, records, data, cyber security and information governance into a clearer long-term approach.

Outlook

20. The mediation pilot is now under way and will be evaluated carefully. It is an important opportunity to test whether earlier, facilitated resolution can improve the experience of complainants and registrants in suitable cases while maintaining appropriate safeguards.

21. Alongside delivery of the 2026 plan, the remainder of the year will focus on responding to the PSA review, developing the 2027 Business Plan and budget, progressing the digital and information governance discovery work, and sustaining improvement in core regulatory performance.

Meetings and engagements

June 2026

- 25 June - Chaired the 2nd quarter Chief Executive's Steering Group
- 27 June – Attended the RCC Summer Conference held in Birmingham
- 30 June - GMC Parliamentary Reception

July 2026

- 2 July – Institute of Regulation, Workforce special interest group meeting on governance
- 8 July - Meeting of the GCC Education Committee
- 10 July – Summer networking event – Mayvin (SMT retained L&D advisors)
- 16 July – Meeting of the GCC Renumeration and HR Committee
- 16 July – Lessons from Regulators on Securing and Delivering Technology Investment Webinar where I spoke on GCC case management system
- 20 July – Meeting with the GOsC to discuss Lord Mann response
- 22 July – UK Chiropractic Forum
- 29 July – Professional Associations CPD discussion meeting
- 30 July – Chaired the July 2026 CEORB meeting
- 31 July – Meeting with the RCC

August 2026

- 20 August – Meeting with the Council Associates to obtain feedback of their time in post
- 27 August – Chaired the August 2026 CEORB meeting

September 2026

- 9 September – NHS England Professional Regulators Forum
- 14 September – Meeting with the GOsC to discuss Lord Mann response
- 18 September – TOC review meeting
- 25 September – Chaired the 3rd quarter CESG meeting

Nick Jones

Chief Executive & Registrar

General Chiropractic Council

For approval

Annex - Case Management System (CMS): Benefits realisation review

Purpose

1. This paper provides Council with a review of the benefits realised from the implementation of the GCC Case Management System against the original business case and success measures. It invites Council to consider the extent to which the anticipated operational, performance and organisational benefits have been achieved and identifies the further work required to optimise the system and maximise the return on investment over the remainder of the contract term.

Background

2. In July 2024, Council approved the implementation of a new Fitness to Practise Case Management System (CMS), selecting Fortesium's Regulator Online solution following a procurement exercise. The business case identified a range of operational, performance, reporting, stakeholder and workforce benefits alongside a significant investment of approximately £124,000 implementation cost and ongoing annual licence costs of approximately £84,000.

3. The business case recognised that the expected benefits would not generate direct cash savings but would instead:

    - improve efficiency and productivity;
    - strengthen data quality and reporting;
    - improve case progression and timeliness;
    - reduce reliance on manual processes;
    - improve stakeholder experience; and
    - support staff retention and resilience.

4. Two years after approval, it is appropriate to review the extent to which those anticipated benefits have been realised and identify any further actions required to maximise return on investment.

5. The original business case anticipated that the CMS would deliver operational and performance improvements rather than direct financial savings. The principal measures identified by Council related to reducing case duration, reducing the number of open cases, improving reporting capability and avoiding the need for additional staffing despite increasing demand.

6. Two years after implementation, the CMS should therefore be assessed not solely on its technical functionality but on the extent to which it has contributed to improved FtP performance, stronger management information, enhanced stakeholder experience and greater organisational resilience. The review should recognise that some benefits are fully realised, some remain dependent on continued process optimisation and staff adoption, and others may only emerge over a longer period as management information and workflow data mature.

Benefits realisation framework

7. The benefits set out by the GCC were as follows:

Theme	Benefit Promised	Status in 2026
Efficiency & Resilience	Automation of routine activities, reduction in manual administration and improved access to case information.	There has been a steady improvement in timeliness of case progression and reduction in average number of open cases.
Efficiency & Resilience	Better business continuity and reduced reliance on personal knowledge of cases.	Faster induction and ability for multiple staff to work effectively on cases.
Accuracy	Reduction in spreadsheet and manual data entry errors. Standardised processes and documentation.	Improved accuracy and consistency of case data. However, further improvements are needed to rely solely on CMS dashboards due to phasing of implementation.
Collaboration	Simultaneous access to case information and improved sharing with Investigating Committee.	Improved collaboration and access to current case information, including sharing with Committee members.
Security	Improved information governance through audit trails, secure access controls and encryption.	Improved security and auditability of records.

Scalability	Ability to support increasing caseloads without material increases in infrastructure or resources.	Supports growth in case numbers whilst maintaining staffing levels. Concern increases in 2025, mirrored in 2026 have been absorbed with team size remaining the same.
Reporting & Analytics	Enhanced reporting, KPI monitoring and management information. Custom reporting capability.	Greater access to management information and performance analysis. However, bespoke dashboards need reworking to allow for efficient reporting. More data collection is required to assist with insights reporting however the capability is present.
Stakeholder Experience	Automated notifications and improved communications. Self-service access for complainants, registrants and defence representatives.	Feedback from Investigating Committee members has been positive, with the system reported as easy to use. While complainants, registrants and representatives do not currently have direct access to the CMS, communications with registrants and their representatives are managed through the system, supporting better filing, record keeping and oversight of actions taken. Further work is required to make fuller use of the system's stakeholder communication capability.
Workforce	Improved staff recruitment and retention through provision of modern technology and improved user experience.	The case management system has allowed some reduced pressure on staff, although implementation clearly had an impact in 2025 and into 2026. It is difficult to measure what impact CMS has had on recruitment and retention.

Success measures approved by Council

8. The business case identified a small number of measurable outcomes against which success could be judged.

Performance Measure	Baseline in Business Case	Target Stated in Business Case	
Median case duration	45-47 weeks	30 weeks by Q2 2026.	38 Q2 2026
Number of open cases	Increased from 47 to 74 over previous 12 months	Fewer than 47 open cases by end 2025.	61 Q2 2026
Case progression timeliness	Not quantified	Steady improvement expected.	Not yet realised
Staffing levels	Existing staffing model	No increase in FtP staffing expected during initial three-year term.	Pre IC workforce remains consistent
Stakeholder satisfaction	No baseline specified	Satisfaction levels expected to grow over time.	Not yet measured

Additional benefits not linked to formal success measures

Qualitative Benefit	Possible Evidence Source
Improved user experience	Staff survey
Reduced administrative burden	Staff focus groups
Improved onboarding of new staff	Induction time and manager feedback
Better case oversight	Manager feedback
Improved disclosure and bundle preparation	Case worker feedback
Better committee access to papers	Committee member feedback
Improved audit trail and compliance	Internal audit findings
Better reporting capability	Number of reports now available versus pre-CMS environment

Overall assessment

Overall, the CMS has delivered important operational benefits and has strengthened the resilience, consistency and oversight of the FtP function. The system has improved access to case information, supported more effective collaboration, allowed processes to be easily updated, enhanced auditability and enabled the team to manage increased demand without a corresponding increase in pre-IC staffing.

However, the formal success measures have only been partially realised: median case duration and open caseload levels have improved from the position described in the original business case but remain above the targets approved by Council, while stakeholder satisfaction and some reporting benefits have not yet been fully measured or embedded. The assessment is therefore that the CMS represents a positive and necessary investment, with clear benefits already realised, but further optimisation of workflows, dashboards and data capture is required to demonstrate full benefits realisation and maximise return on investment over the remainder of the contract term.

Hannah Fellows

Director of Fitness to Practise

General Chiropractic Council

For approval

Performance dashboard

Purpose

Ther dashboard, **annexed at 5a**, demonstrates our progress towards meeting our Strategy, tracking the direction of travel in a structured way using a range of measures that provide a rounded picture of our work.

Overview

Overall delivery of the 2026 Business Plan remains broadly on course, with the programmes progressing. At this stage, the most important issue is not the volume of completed activity, but whether delivery is producing the intended improvement and whether the remaining programme is achievable alongside core work. The senior team is more settled, decision-making is clearer, and we have a firmer grip on delivery and risk. That said, we are not yet where we want to be. A lot has improved in how we work, but the results are not always showing that yet. In simple terms the system is working better, but it is not yet delivering consistently better outcomes.

Aim One - uphold professional standards throughout the education and career of every chiropractor

1. The 2025-2026 CPD cycle has just concluded with 87% of registrants submitting their CPD records by the deadline. We are now sampling 10% of submissions relating to the thematic focus. The final CPD completion and the quality of thematic CPD submissions will be reported in March 2027, following completion of the annual CPD audit cycle. An audit report will be provided to the Education Committee.

2. The new toolkit on Professional Boundaries has been published. The new Safeguarding toolkit is well underway.

3. This year's CPD focus is on Professional Boundaries and the guidance and new toolkit plus monthly scenarios will support registrants with their reflections.

4. Annual monitoring of education providers is complete and the Education review 2026 published.

5. Work is where we expected on the review of our CPD framework (see item on report from Chair of Education Committee).

Aim Two - deliver our core regulatory and registration activities to a high standard

6. FtP is performing well and is stable. Systems are embedded, roles are clearer, and oversight is stronger.

7. The number of referrals across the year remains slightly down compared with 2025 but indicating that the upward trend seen in 2025 is likely to continue.

8. The overall active caseload has reduced, and more hearings are listed in 2026 than in 2025. If all listed cases conclude as planned, this will represent a 44% increase in concluded cases and would be in line with budget assumptions.

9. Our headline median end to end year to date is 120 months, compared to the year-end of 2025 of 123.5. We have 57 cases open at investigation, the lowest since 2023. 15 of the 19 cases pending PCC are scheduled. If all listed cases conclude as planned, this will represent a 44% increase in concluded cases from 2025 and would be in line with budget assumptions.

10. All FtP decisions have been reflected on the Register, and we have audited each change (see PSA report).

11. The Registration Function Review remains on track, with strengthened procedures, controls and assurance arrangements now embedded. Registration KPIs and management reporting are now operational, providing improved oversight of timeliness, quality and operational performance.

12. Following revision of the PSA Standards of Good Regulation, former Standards 10 and 11 are now Standards 8 and 9 respectively. Our assurance and reporting arrangements have been updated to reflect the revised framework.

13. 100% of 143 initial registration applications were processed within the five-working-day KPI, with overall processing performance remaining strong. QA accuracy was 93%, based on 57 records audited. Findings are routinely reviewed to strengthen consistency and address emerging themes.

14. Applicant and registrant experience measures are being developed. Reporting will commence once the new surveys and data collection processes are established.

15. Work has progressed well with the research into understanding non-practising chiropractors and those paying the reduced fee. We have been working with Community Research and an advisory group of registrants.

16. Work continues on the review of the s32 Protection of Title enforcement policy and there is a later agenda item on this.

Aim Three - collaborate to shape the profession's future

17. NCCR is progressing. The new Director position has recently been appointed, with the appointee expected to start in November 2026.

18. We attend quarterly meetings with the UK Chiropractic Forum (UKCF), six monthly meetings with the Forum of Deans and all stakeholders are involved in key areas of work including the CPD review and the review of the Sanctions Guidance.

19. We have actively sought the views of patients and the public through online surveys and focus groups to inform our protection of title work (see later item in agenda); the new online Register, which has gone live, and the Guidance on Sanctions.

20. We have commenced a project to capture student experiences of chiropractic education and create content for people considering chiropractic as a career. Filming is planned at two education providers and the resulting content is expected to be used primarily through Instagram, alongside YouTube and other GCC digital channels, as part of a wider approach to using more engaging student-facing content. Further work will continue next year.

Organisational sustainability and health

a) Finance

21. *Financial performance:* Income, expenditure and the resulting surplus for the period to 31 August 2026 are all broadly in line with forecast. No budget line exceeded the Audit & Risk Committee's 10% variance threshold.

    The forecast cost of Professional Conduct Committee (PCC) hearings for the remainder of the year has increased by £25k. As a result, the dynamic forecast year-end deficit, after allowing for the £50k NCCR grant, has increased to £32k. This remains the main financial pressure for the remainder of the year and will continue to be monitored closely.

22. *Investments, reserves and cash:* Investment values increased by £420k (8.2%) from £5.105m at 31 December 2025 to £5.525m at 31 August 2026, despite continued global uncertainty in the Middle East.

    Unrestricted reserves increased by £605k (15.6%) to £4.488m over the same period, including £1.3m held in designated reserves. Cash at bank stood at £1.2m at 31 August 2026, providing adequate cover for working capital and immediate operational requirements.

23. *Overall position:* The GCC remains in a robust and healthy financial position. While the increased PCC hearing costs have put some pressure on the year-end forecast, the strength of the balance sheet, reserves and cash position provides a sound financial base.

24. Business Plan 2026 – Digital Strategy Development: The project is on track. We have rolled out Copilot to all staff and approved its use as the GCC's AI tool for business purposes. Other AI tools are not currently permitted for work purposes, mainly due to security and compatibility considerations within our Windows environment. The Executive has reviewed an outline scoping report for the GCC's digital strategy, which sets out our current infrastructure, future state requirements and the gaps between the two. By the end of 2026, we aim to complete a draft digital strategy and implementation plan for consideration by the Executive and Council in December 2026.

b) People matters

25. Organisational health is a focus. See also report from the Chair of the Remuneration and HR Committee. The latest staff survey findings present a positive picture overall, with 94% of staff reporting that they are proud to work for the GCC, 88% saying they would recommend the GCC as a great place to work and 100% agreeing that they understand how their role contributes to the organisation's mission. The survey also identified opportunities to continue strengthening employee wellbeing, recognition and cross-team collaboration.

26. The senior team has continued its development programme, focusing on leadership effectiveness, collective accountability and strengthening how the team works together. Taken together, these activities support a positive, engaged and values-led organisational culture.

Recommendation

Council is asked to note and comment on the dashboard and summary

Annex 5a

QUARTER TO SEPTEMBER 2026

Corporate Strategy Performance

44 of 46 measures rated green. 4 of 4 aims on target. 25 delivery commitments in progress.

The Four Aims At A Glance

AIM 1

Standards upheld

OVERALL RATING

Green

- 5 of 5 measures rated green
- 5 awaiting data
- 5 delivery commitments

AIM 2

Core Regulation is maintained to a high standard

OVERALL RATING

Green

- 20 of 22 measures rated green
- 16 awaiting data
- 9 delivery commitments

AIM 3

Shape Future of Profession

OVERALL RATING

Green

- 6 of 6 measures rated green
- 3 delivery commitments

AIM 4

Organisational Health

OVERALL RATING

Green

- 13 of 13 measures rated green
- 8 delivery commitments

Where We Stand

MEASURES RATED GREEN

44 of 46

Across 4 aims

FIGURES REPORTED

25 of 46

Reported this quarter

NEEDING ATTENTION

4

4 worsening, 0 off target

DELIVERY COMMITMENTS

25

Activity, Output and Outcome

AIMS REPORTED

4

46 measures, 25 commitments

Trend across all measures

Aim 1 Standards upheld

Table 1: Performance Measures

OVERALL RATING

Green - On target

MEASURE	ACTUAL	TREND	TARGET	RAG
% of registrants referred to FTP compared with total number on Register	TBC	↔ Stable	Downward trend	Green
% of registrants who have completed CPD due Sept 26	Not due	↔ Stable	>95%	Green
Quality of thematic CPD submissions audited	Not due	↔ Stable	100%	Green
% of programmes that meet Education Standards	TBC	↔ Stable	100%	Green
PSA Standards for Education and Training (6) and Quality Assurance of Education (7), due Sept 27 -- passed	TBC	↔ Stable	100%	Green

Aim 1 Standards upheld

Table 2: Delivery: from Activity to Outcome · rows 1 to 3 of 5

Activity (What we are doing)	Output (What we are delivering)	Outcome (What difference or impact we are making)	Status
Provide guidance and information	2 new toolkits for 2026	Guidance applied in practice; positive survey score >75%	Green
Redefine and implement new CPD framework	Phase 1 completed in 2026	Registrants find CPD useful and relevant; >75% positive	Green
Culture of safety in profession	CPD mandatory safety element in 25/26	Stronger culture of safety	Green

Aim 1 Standards upheld

Table 2: Delivery: from Activity to Outcome · rows 4 to 5 of 5

Activity (What we are doing)	Output (What we are delivering)	Outcome (What difference or impact we are making)	Status
Culture of safety in profession	Publish expert group findings	Improved understanding of safety issues	Green
Continue our rolling programme of education quality assurance	Feb/March 27: annual monitoring carried out. April 27: identify focused theme for 27/28	Education programmes produce quality graduates	Green

Aim 2 Core Regulation is maintained to a high standard

Table 1: Performance Measures

OVERALL RATING

Green - On target

MEASURE	ACTUAL	TREND	TARGET	RAG
All PSA targets are met	**16/18**	↓ Negative	18/18	Green
FTP process and approach is fair, timely, provides regulatory certainty and protects the public	TBC	↔ Stable	>95%	Green
Survey of complainants % scoring positive re: ease of raising a complaint	TBC	Not yet rated	>75%	Future deadline
Survey of new registrants scoring positive re registration process	TBC	Not yet rated	>75%	Green

Measures 1 to 4 of 7 in this table.

Aim 2 Core Regulation is maintained to a high standard

Table 1: Performance Measures

OVERALL RATING

Green - On target

MEASURE	ACTUAL	TREND	TARGET	RAG
Quarterly audits of sampled registrants	TBC	Not yet rated	100%	Green
Linked FtP annotations updated according to agreed standard	TBC	Not yet rated	100%	Green
Accuracy of registrant numbers (Finance and IMIS)	TBC	Not yet rated	100%	Green

Measures 5 to 7 of 7 in this table.

Aim 2 Core Regulation is maintained to a high standard

OVERALL RATING

Green - On target

Table 1: Performance Measures - FtP and Registration

MEASURE	ACTUAL	TREND	TARGET	RAG
PSA Standard 8: a) % of sampled registration records meeting quality requirements	TBC	Not yet rated	100%	Green
PSA Standard 8: b) % of required register updates published accurately and within agreed timescale	TBC	Not yet rated	100%	Green
PSA Standard 8: c) % of forms entered correctly each month	TBC	Not yet rated	90%	Green
PSA Standard 8: d) days to process complete applications	TBC	Not yet rated	<5	Green
PSA Standard 9: a) % of registration applications and appeals completed within agreed timescales	TBC	Not yet rated	100%	Green

Measures 1 to 5 of 15 in this table.

Aim 2 Core Regulation is maintained to a high standard

OVERALL RATING

Green - On target

Table 1: Performance Measures - FtP and Registration

MEASURE	ACTUAL	TREND	TARGET	RAG
PSA Standard 9: b) % of positive applicant/registrant feedback on the registration and appeals process	TBC	Not yet rated	100%	Green
PSA Standard 9: c) % of applicants satisfied with the initial registration process	TBC	Not yet rated	95%	Green
PSA Standard 9: d) % of registrants satisfied with the retention/renewal process	TBC	Not yet rated	95%	Green
PSA Standard 9: e) % of positive overall user experience feedback	TBC	Not yet rated	95%	Green
Median weeks for open enquiries (rolling 12 months)	4 weeks	↔ Stable	<4 weeks	Green

Measures 6 to 10 of 15 in this table.

Aim 2 Core Regulation is maintained to a high standard

OVERALL RATING

Green - On target

Table 1: Performance Measures - FtP and Registration

MEASURE	ACTUAL	TREND	TARGET	RAG
Median weeks for open complaints (rolling 12 months)	**36 weeks**	↑ Positive	<40 weeks	Green
Median weeks for open PCC cases (IC to PCC) (rolling 12 months)	**33 weeks**	↑ Positive	<35 weeks	Green
Median weeks complaint to PCC decision (end to end) (rolling 12 months)	**99 weeks**	↑ Positive	<99 weeks	Green
Survey of those involved in mediation % scoring positive	TBC	Not yet rated	>80%	Future deadline
% of investigation cases over 52 weeks (rolling 12 months)	**31%**	↓ Negative	<15%	Green

Measures 11 to 15 of 15 in this table.

Aim 2 Core Regulation is maintained to a high standard

Table 2: Delivery: from Activity to Outcome

Activity (What we are doing)	**Output** (What we are delivering)	**Outcome** (What difference or impact we are making)	**Status**
Review registrants fee structure/categories	Q2 2027: option paper for ARC and Council. Dec 2027: reviewed categories and fee structure in place and published	Ensuring regulatory best practice in relation to fees and categorisation of registration status	**Future deadline**
Review approach to enforcing protection of title	2026: research. 2027: consultation. 2027: implementation	Upholding and maintaining reputation of the profession and the regulator	**Green**

Aim 2 Core Regulation is maintained to a high standard

Table 2: Delivery: from Activity to Outcome - Registration · rows 1 to 4 of 7

Activity (What we are doing)	Output (What we are delivering)	Outcome (What difference or impact we are making)	Status
Maintain and publish accurate register for those who meet registration and practice requirements	Accurate and up-to-date register published	The register has integrity. The public can have confidence that those on the register meet the requirements to practise	**Not rated**
Set KPI benchmark for registration processes	—	The registration model is working efficiently, fairly and timely to ensure the register has integrity	**Not rated**
Review registration processes	—	The registration model is working efficiently, fairly and timely to ensure the register has integrity	**Not rated**
Registration and appeals processes operate proportionately, fairly and efficiently (PSA Standard 9)	Registration and appeals decisions are fair, proportionate and efficient	Applicants and registrants are treated fairly and confidence in the registration process is maintained	**Not rated**

Aim 2 Core Regulation is maintained to a high standard

Table 2: Delivery: from Activity to Outcome - Registration · rows 5 to 7 of 7

Activity (What we are doing)	Output (What we are delivering)	Outcome (What difference or impact we are making)	Status
Develop registration customer experience measures, including retention survey, Initial Registration survey and pulse survey	Create routine satisfaction and feedback measures for initial registration, retention and user experience, rather than relying solely on processing times	Registrants receive a positive, effective, fair and proportionate registration service	Not rated
Review FTP approach	New efficient process in place March 2027	FtP processes are operating efficiently, fairly and timely	Not rated
Agree alternative operating models for FTP	Develop alternative operating model for FTP legal hearing costs: June 2026. Clear decisions on alternative effective operating models: September 2026	—	Not rated

Aim 3 Shape Future of Profession

Table 1: Performance Measures

OVERALL RATING

Green - On target

ITEM	MEASURE	ACTUAL	TREND	TARGET	RAG
Research into public, patient and registrant perspective and experience	Built into projects and areas of work as required	**On track**	↑ **Positive**	Projects delivered as planned	**Green**
NCCR collaboration is making a difference	NCCR progress is as expected	**Delayed progress**	↓ **Negative**	Pass	**Green**
Engagement with stakeholders including UKCF, CPV	Delivery against plans for stakeholder engagement	**Achieved**	↔ **Stable**	Targets achieved as planned	**Green**

Measures 1 to 3 of 6 in this table.

Aim 3 Shape Future of Profession

Table 1: Performance Measures

OVERALL RATING

Green - On target

ITEM	MEASURE	ACTUAL	TREND	TARGET	RAG
Improved visibility and reputation of GCC amongst stakeholders	Number of users accessing register	**On track with relaunched register**	↔ **Stable**	Upward trend	**Green**
Perceived as a "modern regulator" and a proactive partner in developing the profession	PSA Standard 4	**Met**	↑ **Positive**	Pass	**Green**
Perceived as a "modern regulator" and a proactive partner in developing the profession	PSA stakeholder feedback highlights positive examples	**Met**	↑ **Positive**	Upward trend	**Green**

Measures 4 to 6 of 6 in this table.

Aim 3 Shape Future of Profession

Table 2: Delivery: from Activity to Outcome

Activity (What we are doing)	**Output** (What we are delivering)	**Outcome** (What difference or impact we are making)	**Status**
Research into public, patient and registrant perspective and experience	Built into projects and areas of work as required	Policies and decisions are informed by patient and registrant experience	**Green**
NCCR collaboration is making a difference	NCCR progress is as expected	Perceived as a modern regulator and a proactive partner in developing the profession	**Green**
Engagement with stakeholders including UKCF, CPV	Delivery against plans for stakeholder engagement	Improved visibility and reputation of GCC amongst stakeholders	**Green**

Aim 4a Organisational Health - Finance and Sustainability

Table 1: Performance Measures

OVERALL RATING

Green - On target

MEASURE	ACTUAL	TREND	TARGET	RAG
Budget variance income and expenditure YTD [as of August 2026]	**<10%**	↔ **Stable**	<10% per Qtr	**Green**
Income YTD	**£2.484m**	↑ **Positive**	£2.484m	**Green**
Costs YTD	**£2.317m**	↓ **Negative**	£2.319m	**Green**
Surplus YTD	**£166k**	↑ **Positive**	£165k	**Green**
Forecast annual surplus	**<=1%**	↔ **Stable**	<=1%	**Green**

Measures 1 to 5 of 13 in this table.

Aim 4a Organisational Health - Finance and Sustainability

Table 1: Performance Measures

OVERALL RATING

Green - On target

MEASURE	ACTUAL	TREND	TARGET	RAG
Working capital at quarter end	**£1/£1**	↔ Stable	average £1/£1	Green
Reserves at quarter end	**£4.488m**	↑ Positive	£3.883m	Green
Real value of investment portfolio: benchmark distribution level as adjusted	**£5.525m (Aug 2026)**	↑ Positive	£5.030m (Dec 2026)	Green
IT support service levels met	**SLA targets met**	↔ Stable	99%	Green
Number of data breaches upheld by ICO	**Zero**	↔ Stable	Zero	Green

Measures 6 to 10 of 13 in this table.

Aim 4a Organisational Health - Finance and Sustainability

Table 1: Performance Measures

OVERALL RATING

Green - On target

MEASURE	ACTUAL	TREND	TARGET	RAG
% of FOI/SAR requests unresolved within time	**Zero**	↔ **Stable**	Zero	**Green**
% of Corporate Complaints unresolved within time limits	**Zero**	↔ **Stable**	Zero	**Green**
% of staff happy with GCC (proud to work for the GCC, July 2026 staff engagement survey)	**94%**	↔ **Stable**	90%	**Green**

Measures 11 to 13 of 13 in this table.

Aim 4a Organisational Health - Finance and Sustainability

Table 2: Delivery: from Activity to Outcome

Activity (What we are doing)	**Output** (What we are delivering)	**Outcome** (What difference or impact we are making)	**Status**
Develop financial strategy to enable investment	Approved 2026-2030 Financial and Investment Strategy	Long-term financial sustainability and capital growth enabling proactive investment in core regulatory and operational priorities	Green
Develop digital strategy for efficiency and user focus	Modern, accessible digital portal and upgraded core online services	Using our digital facilities becomes fast, clear and effortless for registrants, staff and other users, saving them time and frustration	Green
Evaluate and deploy AI capabilities	AI roadmap and implemented automation tools	Increased staff productivity and operational efficiency, automating repetitive administrative workflows and improving decision support	Green
Model registrant fee sustainability	2026-2030 fee structure and viability assessment	Fair, predictable and inflation-resilient revenue model, maintaining long-term financial independence without placing unnecessary burden on registrants	Green
Financial modelling for GCC is complete	2027 budget sustainable and approved by Council by Dec 26	Maintain rigorous, risk-adjusted budget modelling to enable the Executive and Council to allocate resources effectively	Green

Aim 4b Organisational Health - People

Table 3: Delivery: from Activity to Outcome

Activity (What we are doing)	Output (What we are delivering)	Outcome (What difference or impact we are making)	Status
Set up a "Speak Up" Guardian	An appointed Guardian with clear rules on how staff can speak up confidentially	Staff feel safe to speak up about problems early, knowing they will be taken seriously and be protected	Green
Check workforce morale and workplace culture	An annual staff survey and a clear summary report of results	We learn what staff really think about working here, giving management the facts needed to fix problems and make the workplace better	Green
Improve how we talk and work with key partners	A clear plan and schedule for regular meetings and updates with our partners	Stronger working relationships with partners, leading to fewer misunderstandings, better trust, and smoother day-to-day co-ordination	Green

Where Attention Is Needed

4 of 46 measures are either rated amber or red, or moving in the wrong direction. Of the remaining 42, 40 are rated green and 2 carry a future deadline.

	ACTUAL	TREND	TARGET	RAG
All PSA targets are met Aim 2	16/18	↓ Negative	18/18	Green
% of investigation cases over 52 weeks (rolling 12 months) Aim 2	31%	↓ Negative	<15%	Green
NCCR progress is as expected Aim 3	Delayed progress	↓ Negative	Pass	Green
Costs YTD Aim 4a	£2.317m	↓ Negative	£2.319m	Green

IN SUMMARY

- → 44 of 46 performance measures are rated green, and 4 of 4 aims are on target.
- → 25 measures carry a reported figure this quarter, covering 54% of the measure set.
- → 4 measures need attention, led by: All PSA targets are met.
- → 25 delivery commitments are tracked from Activity through Output to Outcome, 17 of them on track.
- → 4 aims are reported on: Aim 1, Aim 2, Aim 3, Aim 4.

General Chiropractic Council

For noting

Professional Standards Authority: Performance Review 2025/26

Purpose

This paper reports the outcome of the Professional Standards Authority's published periodic review of the General Chiropractic Council's performance during 2025/26. It outlines the findings, the action being taken in response, and the PSA's escalation of its concerns about fitness to practise timeliness through correspondence by the Chair of the PSA to the Chair of Council.

Recommendations

Council is asked to:

1. note the outcome of the PSA's published 2025/26 Performance Review;
2. note and endorse the GCC's response to the findings on Standards 10 and 15;
3. note the letter from the Chair of the PSA to the Chair of Council concerning Standard 15;
4. discuss that letter in the light of matters considered in this item, and agree the Chair's response be issued soon after this meeting, amongst other things acknowledging the seriousness of the finding, describe Council's oversight of the improvement programme and set out how progress will be monitored; and
5. agree that the response to the letter be published.

Background and overall outcome

1. The PSA has a statutory duty to report annually to Parliament on the performance of the ten health and social care regulators it oversees. Performance reviews assess regulators against the Standards of Good Regulation. Reviews operate on a three-year cycle, comprising a more intensive periodic review followed by two monitoring reviews. The 2025/26 review of the GCC was a periodic review and covered the period from 1 July 2025 to 30 June 2026.

2. The PSA published its report on 21 September 2026 determining that the GCC met 16 of the 18 Standards of Good Regulation. Standards 1 to 9, 11 to 14 and 16 to 18 were met. Standard 10, concerning the accuracy of the public register, and Standard 15, concerning the timely progression of fitness to practise cases, were not met.

3. The outcome should be viewed in the round.

4. We did not meet the required standard in two areas. We accept both findings. The nature of the two issues is, however, different and our response needs to reflect that distinction.

Standard 10: accuracy of the register

5. The PSA reviewed register entries associated with fitness to practise decisions and identified two sanctions applied that had not been correctly reflected on the public register. A similar error had been identified in 2023/24. It concluded that, although the errors were few in absolute terms and concerned low-level sanctions, they represented a high proportion of the sanctions imposed during the year and demonstrated that sufficient controls were not in place.

6. This represents a failure of our processes and assurance controls. The public and other users must be able to rely on the register, including information about restrictions on practice. The entries were corrected promptly, but our review found weaknesses across the end-to-end process rather than an isolated operational error.

7. Corrective action includes clearer ownership of implementing sanctions, formalised cross-team processes, quality assurance checkpoints and audit trails, stronger monitoring, and greater management oversight. Approval by senior Fitness to Practise staff is now required before notices involving a registration change are issued. A standard operating procedure has been implemented for these checks, and changes made to the Register are subject to subsequent audit by the Registration Manager to verify that they have been implemented correctly. These measures build on the Registration Action Plan and Quality Assurance Framework already underway and incorporate the specific lessons identified through our review of these cases.

8. The executive owns this and the resulting need for improvement. The PSA's 2026/27 monitoring plan will seek evidence of our internal quality assurance checks and will monitor the accuracy of the register. We are ready to demonstrate that the strengthened controls are embedded and operating effectively.

Standard 15: fitness to practise timeliness

9. Standard 15 has not been met for a third consecutive year. The PSA concluded that, although timeliness has improved at the earlier stages of the process, the end-to-end time from receipt of a referral to a final hearing remains comparable with the previous

year. It also identified increases in the number of cases awaiting a final hearing and in open cases over 52 weeks old.

10. We understand the importance of this finding. Delays affect complainants and registrants, can undermine procedural fairness, and may affect public confidence. Improvements in systems, staffing and internal processes must be demonstrated through the timely resolution of cases, not simply through evidence of activity.

11. This must be considered alongside the PSA's wider assessment. Having reviewed all cases closed in the period its audit found investigations generally robust, with relevant evidence and expert advice obtained where appropriate, and cases progressed proactively. Only one delay identified by the audit occurred during the review period.

12. The PSA also concluded that we make robust and reasonable decisions at each stage of our fitness to practise process. It did not appeal any final hearing decision during the year and has not done so since 2014. It found no significant concerns about our decision-making and was satisfied that the associated Standard was met.

13. Timeliness is part of a broader regulatory judgement. Cases must progress as quickly as possible, but also be investigated thoroughly, determined fairly and resolved safely. Improvement must not compromise investigation quality, participation or independent adjudication.

14. Our improvement programme includes a new case management system, revised processes, increased staffing, stronger oversight, greater productivity of the Investigating Committee and additional hearings capacity. The PSA recognised earlier-stage improvement and that we understand the causes of later-stage delays, with plans and the budget to increase hearing activity.

15. Alternative resolution, including the mediation pilot, forms part of this work. It is not a solution to historic hearing delays, and cases should not be diverted merely to improve figures. Properly designed, it may provide a more proportionate route for suitable concerns, improve participants' experience and generate better information. The PSA welcomed the plans and will monitor the pilot.

16. Our small caseload creates volatility. As the PSA notes, quarterly fluctuations are not unusual: a few older, complex or adjourned cases can materially affect median end-to-end performance. Improvements will not be fully evident until sufficient cases pass through the whole system.

17. This context does not remove our responsibility or lessen the effect of delay. It does mean performance should be judged across case age and risk, progress at each stage, investigation and decision quality, participant experience and end-to-end timeliness. We seek sustained improvement across all these measures.

18. We have modelled the expected impact of the improvement programme on timeliness. Current projections indicate that end-to-end timeliness should return within tolerance by PSA quarter 3 of 2027/28 (31 December 2027). In the meantime,

performance is expected to deteriorate across the three key median measures — referral to Investigating Committee decision, Investigating Committee decision to final Professional Conduct Committee decision, and referral to final Professional Conduct Committee decision — as older cases are progressed. Modelling suggests median case ages will peak in Q1 2027/28 before improving.

19. The key lead indicator of improvement in line with the modelling work will be the number and proportion of cases over 52 weeks at the pre-IC stage each quarter.

Escalation and GCC response

20. Because Standard 15 has not been met for three consecutive years, the PSA considered escalation to the Secretary of State. The panel described the decision as finely balanced, noting limited improvement in end-to-end timeliness and more older cases.

21. The panel also recognised earlier-stage improvements, measures implemented by the GCC, action on staff turnover, the absence of evidence that delays had created actual public-protection risks, and the low case volume. Its concern was not comparable with cases previously escalated to the Secretary of State.

22. The PSA therefore decided that its Chair should write to the GCC Chair. We must respond clearly. The Chair's response will acknowledge the finding, confirm Council's ownership and oversight, and explain how it will hold the executive to account for improved end-to-end performance while preserving the quality, fairness and public-protection strengths identified by the PSA. We will publish our response, demonstrating transparency without minimising the finding or responding defensively. It will set out the assurance Council has sought, action under way and outcomes expected.

Next steps

23. The PSA's 2026/27 monitoring review will use its new Standards and cover register accuracy and assurance, fitness to practise timeliness, higher-risk cases, the Guidance on Sanctions, mediation and our response to the 2025/26 findings.

24. Progress will be incorporated into reporting to Council. For registrations, we must show that controls are embedded and effective. For fitness to practise, reporting must show delivery and its effect on case progression and outcomes.

Nick Jones

Chief Executive & Registrar

General Chiropractic Council

For approval

Guidance on Sanctions

Purpose

Council is asked to consider the consultation report, the proposed publication version of the updated Guidance on Sanctions, and the Equality and Welsh language impact assessment. The consultation has now concluded, stakeholder responses have been analysed, and revisions have been made to the guidance. Council's approval is sought to publish the updated and reworked guidance to take effect from 1 November 2026.

Summary

1. The current Guidance on Sanctions dates from 2018 and has provided an important framework for the Professional Conduct Committee and Health Committee when determining proportionate sanctions. As set out in the June 2026 paper, the guidance required review to ensure it remains clear, current and capable of supporting fair, consistent and transparent decision-making focused on public protection. Following Council's approval in June 2026 we undertook a formal consultation on the proposed guidance.

2. The public consultation concluded and the analysis paper **(07a)** sets out the engagement received, the main themes raised by respondents, and our response to those. Feedback was received from a range of stakeholders and has helped test both the clarity of the proposed guidance and its practical utility for those involved in fitness to practise proceedings.

Primary changes following consultation

3. We were pleased with the breadth and quality of engagement. Responses were considered and meaningful, and we have sought either to incorporate the feedback into the guidance where appropriate or to explain, in the analysis paper, why particular suggestions have not resulted in drafting changes.

4. The primary changes remain as follows:

    - clarifying the stages of decision-making and improving the structure of the guidance so it better reflects committee workflow;

- strengthening guidance on proportionality, reasons, public protection and the need to avoid double-counting or conflating evidential findings with sanction considerations;
- expanding and refining the treatment of aggravating and mitigating factors, insight, remediation and supporting evidence;
- updating guidance on individual sanctions, review hearings, interim orders and particular case categories, including dishonesty, sexual misconduct, discrimination, and clinical failings; and
- integrating equality, diversity, inclusion, fairness, accessibility and Welsh language considerations more explicitly.

5. The guidance **(07b)** now presented to Council is the proposed version for publication to take effect from 1 November 2026. It reflects the structured review described in the June paper and the further revisions made following consultation. If approved, the guidance will replace the 2018 version and will be supported by clear communications with stakeholders.

Alignment to strategy, risks and budget

6. This work supports the GCC's overarching objective of protecting the public by strengthening the framework used when sanctions are considered and applied. Clearer and updated guidance will support greater consistency and transparency in decision-making, reduce the risk of avoidable variation, and help ensure fitness to practise outcomes remain aligned with current regulatory expectations and good practice.

7. The revisions also support the effective implementation of the 2026 Code of Professional Practice by helping committees apply sanctions in a way that is proportionate, evidence-based and clearly reasoned.

8. The work can be met within existing budgets. The Equality and Welsh language impact assessment has been updated **(07c)** alongside the guidance and supports the Council's commitment to accessible, fair and inclusive regulation.

Recommendations

Council is asked to approve publication of the updated Guidance on Sanctions to take effect from 1 November 2026, together with the attached consultation analysis paper and supporting Equality and Welsh language impact assessment.

Hannah Fellows

Director of Fitness to Practise

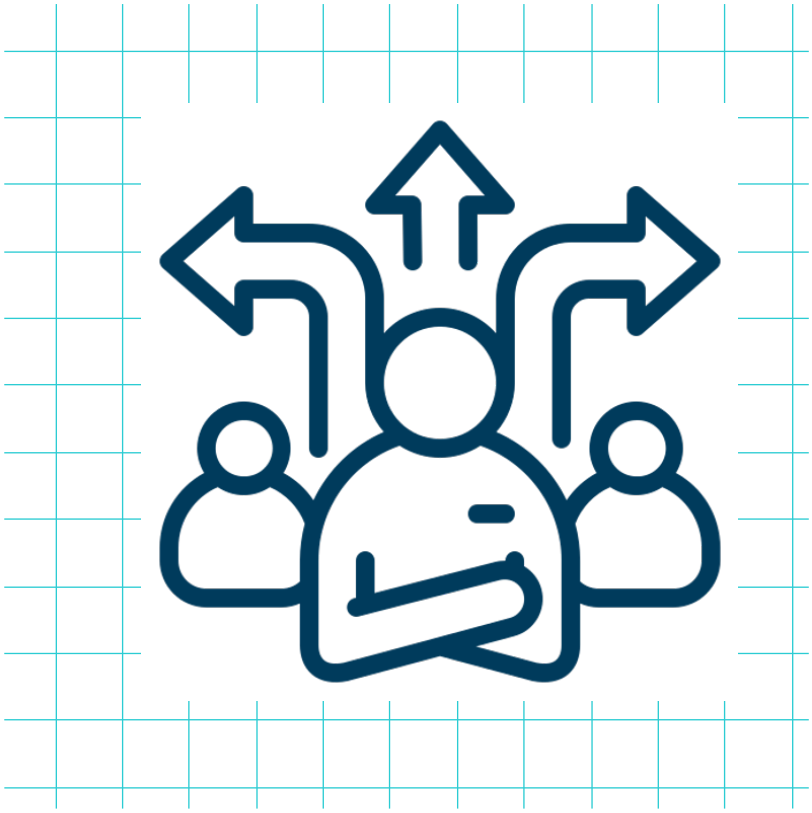
General Chiropractic Council

Consultation Report

The General Chiropractic Council's Guidance for Decision Makers: Sanctions.

The process of consultation, findings and outline of resulting changes to the final guidance.

Published November 2026.



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Abstract

This report summarises the development of the General Chiropractic Council (GCC) Guidance for Decision Makers: Sanctions, and the findings of the consultation into the guidance held from 29 June 2026 to 16 August 2026.

The report also highlights the substantive changes to the guidance as a result of comments and feedback received during the consultation.

Background

The need for guidance on sanctions

The GCC's previous sanction guidance had not been updated since 2018. It therefore required updating to reflect changes in law, regulatory practice and expectations since it was last published.

Experience from Fitness to Practise cases, learning from the Professional Standards Authority and developments across healthcare regulation also showed that decision makers needed clearer, more comprehensive support.

The revised guidance was therefore developed to promote fair, consistent and proportionate decisions, provide a clearer staged approach to selecting the minimum sanction necessary to protect the public, and give fuller guidance on matters including insight and remediation, aggravating and mitigating factors, particular categories of case and review hearings.

Development of the guidance

The guidance was developed through a thorough legal review of the 2018 guidance, relevant legislation and case law, learning from Fitness to Practise cases and feedback from learning points. We also considered current sanction guidance and emerging practice across other healthcare regulators to identify areas where the GCC guidance could be clearer, more comprehensive and better aligned with contemporary regulatory practice.

Drawing on this work, we produced a substantially revised draft with a clearer staged approach to decision making and expanded guidance on the available sanctions, insight and remediation, aggravating and mitigating factors, particular categories of case, review hearings and Health Committee proceedings. The draft was then refined through internal legal and policy review and early engagement with key stakeholders before being presented to Council for approval to consult.

Consultation

At its June 2026 meeting, Council agreed that the draft guidance should be published for consultation with the public, registrants and other key stakeholders.

The purpose of the consultation was to seek the views of stakeholders and explore the feasibility and practical implications of the proposals during the Fitness to Practise process.

The primary consultation tool was an online survey (appendix 1).

As well as messaging chiropractors directly through the usual channels (newsletters, email signatures and social media) we wrote to the four professional associations, and the Royal College of Chiropractors, to help them engage their members with the consultation and assist them with developing their organisational response to the consultation.

During the consultation period, the GCC met with representatives of the professional associations and their legal representatives during a regular Quarterly Defence Meeting. The consultation was also discussed at the first meeting of the Registrant Health Working Group.

We also considered relevant recent guidance and recent consultations from other health regulators and other bodies. This included:

- The Health and Care Professions Council Sanctions Policy, (March 2026);
- The Guidance for Medical Practitioners Tribunal Hearings (September 2025)
- The General Dental Council Guidance for the Practice Committees and Conditions Bank for Practice Committees (January 2026)
- The General Optical Council Hearings and Indicative Sanctions Guidance (June 2026)

We reviewed best practice and research shared by the Professional Standards Authority. This included:

- Learning points shared with the GCC following concerns with previous committee decisions (unpublished).
- Research Report: Improving the handling of sexual misconduct cases in fitness to practise (September 2026)

We have carefully reflected on all the comments, themes, issues and feedback received when preparing this report, and the final guidance, for presentation to Council in September 2026.

Substantive changes made to the final guidance

The following table highlights the substantive changes made to the final guidance following the consultation. Links in “Comment” point to relevant thematic discussion arising from the consultation. Paragraph numbers refer to the numbering of the final guidance.

Change made	Comment
Changes for readability and navigation	
Throughout the document some changes have been made to aid readability, increase consistency and assist in navigation.	Headings have been reworded or added. Sections have been moved or condensed where content was repeated. Sections have been reordered so that they have a consistent structure. References to sections of the Act have been moved to footnotes. Hyperlinks to elsewhere in the guidance are now “in line”. Statements have been split into multiple parts.
Participation in proceedings using the Welsh Language	
Paragraph 7 added	GCC duty to comply with the Welsh language standards.
The nature of allegations	
Paragraph 14 edited	Edited to reflect the allegations set out in the act. Allegation “a)” has been split into two sentences. The first sentence reflects the legislation, the second sentence defines “UPC”. Allegation c) has been clarified to better define an allegation of criminal offence.
The staged approach	
Paragraphs 22 and 23 moved	The paragraphs have been moved earlier in the guidance.

Change made	Comment
Paragraphs 24 and 25 added	Added to be clearer about how a committee should respond when it finds an allegation is, and is not, well founded. If an allegation is well founded (and in the case of conviction also materially relevant) there is no option not to apply a sanction.
Overview of Available Sanctions	
Paragraph 38 updated	Clarifies that the registrant has the right to appeal sanctions imposed by the Health Committee as well as those imposed by the PCC.
Conditions of Practice Order	
Paragraph 52 updated	Following a comment from a lay member of an FTP committee, the paragraph clarifies that the conditions bank is not exhaustive.
Paragraph 56 added	Considers the reasons for the duration of the Conditions of Practice Order.
Paragraph 57 added	Details of order will be published against the registrant's entry in the register.
Paragraph 59-62 edited	Condensed and standardised across sanctions. The approach to Review Hearings has been moved to a separate section.
Suspension Order	
Paragraphs 68-70 edited	Considers the reasons for the duration of the Suspension Order.
Paragraph 72 added	Details of order will be published against the registrant's entry in the register.
Removal Order	
Paragraph 82, point b) added	A new definition brings parity with the GMC and other regulators.
Paragraph 83 added	Details of order will be published against the registrant's entry in the register.

Change made	Comment
Harm caused or risk of harm	
Paragraphs 88-91 reordered and a new paragraph added	Reordered for clarity due to conflation of “harm” and “risk”. New paragraph added to address deliberate or reckless conduct.
Assessing insight and remediation	
Paragraphs 95-101 reordered and new paragraphs added	Expanded on how to evidence insight and remediation, and specifically the advantages and disadvantages of assessing oral and written evidence.
Paragraphs 102-104 added	New section on the role of apologies.
Paragraph 107 added	The importance of corroborating the depth of insight from multiple evidence sources.
Paragraph 114 edited	Expanded to include consideration of whether remediation is possible, and examples of activities which may demonstrate a reduction in future risk.
Previous regulatory concerns	
Paragraphs 118, 119 altered.	Examples of previous regulatory concerns have been clarified. The revision is clearer that any finding of fact by a regulator (whether it led to a sanction or not) could illustrate a repetition of conduct.
Proceedings where a chiropractor is unrepresented	
Paragraphs 125-127 added	Support and assessment of unrepresented chiropractors.
Considering previous interim suspension orders	
Paragraphs 128-130 edited	Redrafted to be clearer with references to the relevant caselaw.

Change made	Comment
Mitigating and Aggravating Factors	
Paragraph 138 added	Systemic issues as mitigation.
Paragraph 140 and 141 expanded	Expanded for consistency and to highlight the importance of considering weight and relevance of aggravating factors. Further factors (abuse of vulnerability, deliberate or reckless acts, safeguarding concerns) added.
Particular categories of cases	
Paragraph 143 added	Bullet point index added to aid navigation
Convictions	
Paragraph 144-146 added	The guidance now aligns the definition of a conviction within the Act, and how other criminal conduct (e.g. abroad or out-of-court disposals) is dealt with.
Paragraphs 147 -158 expanded	The process has been separated into sections to reflect the staged approach. New paragraphs added to consider multiple convictions from the same event; discharges and alcohol related convictions.
Sexual misconduct	
Paragraph 159 added	Sets the context of the seriousness of the conduct on the victim and impact on trust and confidence in the profession.
Paragraph 160 expanded	Further categories of sexual misconduct included
Paragraph 162 added	Clarification to reflect the guidance in the Guidance for Registrants – Professional Boundaries.
Paragraph 164 expanded	Expanded to include Children and Adult Barring lists as well as Sex Offenders Register.

Change made	Comment
Dishonesty and lack of integrity	
Paragraph 166 – 175 expanded	Expanded to include lack of integrity as linked, but separate, aspects of conduct. This reflects a similar section in General Dental Council guidance.
Failing to provide an acceptable level of treatment or care	
Paragraph 176 added	Sets the context of the seriousness of the conduct on the victim and impact on trust and confidence in the profession.
Paragraph 179 expanded	The section now also suggests factors to consider when assessing clinical failings.
Paragraph 180 expanded	Clinical failings may be remediable (where there is insight) through training or learning
Discrimination and harassment	
Paragraph 181 added, Paragraphs 181-189 expanded.	Sets the context of the seriousness of the conduct on the victim and impact on trust and confidence in the profession, with particular reference to groups who already experience barriers to accessing care. Section expanded to include the consideration of discrimination which may not meet the legal threshold of being unlawful and analysis of its seriousness and impact.
Exploitation of vulnerability and victimisation	
Paragraphs 190-196	Sets the context of the seriousness of the conduct on the victim and impact on trust and confidence in the profession. Section expanded to include factors that lead to vulnerability, inappropriate relationships that are not sexual and assessment of vulnerability and seriousness.

Change made	Comment
Review Hearings	
Paragraph 197 - 219	This section has been expanded using information that was previously repeated for each sanction. The section on review hearings now follows a staged approach.
Interim Suspension Orders	
Paragraph 221 added	An ISO is should not be considered as an automatic outcome.
Health Committee	
Paragraph 224-245 expanded	Detail on the Sanctions Available to the Health Committee is expanded to reflect other (PCC) sanctions.
Related Documents	
References page expanded	A new section “Other Relevant legislation, rules, guidance and policies” has been added to the document after the References.

Consultation reach at a glance

Communications and engagement activity

The consultation was supported by a dedicated communications and engagement plan. Activity included a consultation webpage, stakeholder communications, newsletter coverage, LinkedIn promotion and consultation-specific staff email signatures.

The consultation featured in both the registrant and stakeholder editions of the GCC July newsletter, generating 43 total clicks to the consultation content (31 from registrants and 12 from stakeholders). A further reminder was included in the August registrant newsletter, ahead of the consultation date, generating an additional 24 clicks to the consultation page.

Four dedicated LinkedIn posts promoted the consultation during the consultation period:

- Launch post (8 July 2026): 273 impressions, 14 clicks, 7 likes and 3 reposts.
- Explainer post (17 July 2026): 241 impressions, 7 clicks and 2 reposts.
- Final weekend reminder (14 August 2026): 209 impressions, 7 clicks, 4 likes and 2 reposts.
- Closing day reminder (16 August 2026): 139 impressions, 2 clicks and 1 like.

Across the four consultation-specific LinkedIn posts, activity generated a combined 862 impressions, 30 clicks, 12 likes and 7 reposts.

A consultation-specific email signature was also introduced for staff during the consultation period, providing ongoing promotion through routine correspondence. This was clicked 225 times.

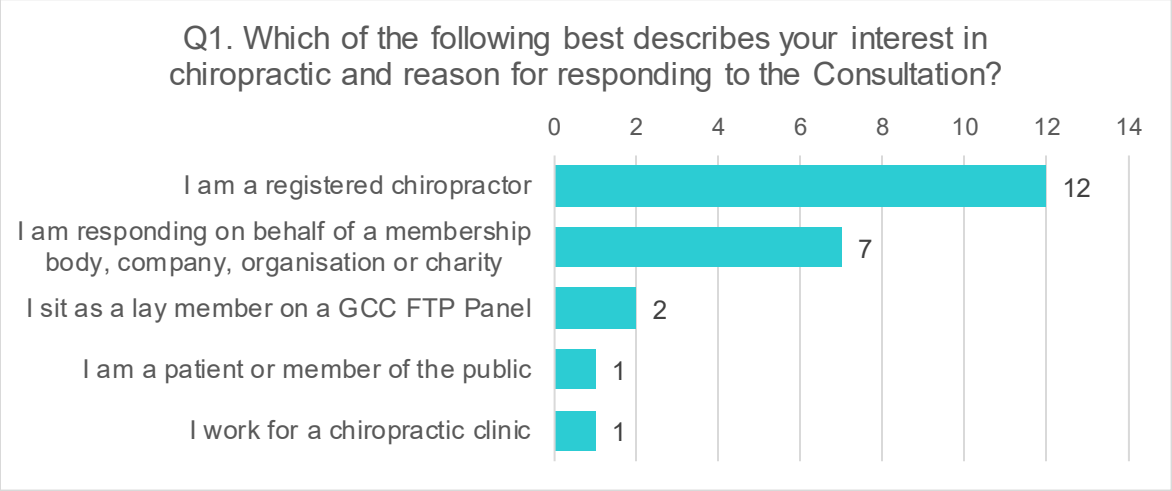
In total the webpage was viewed 367 times by 252 active users. There were 46 clicks from the website to the consultation form and the form was started 35 times.

Consultation responses

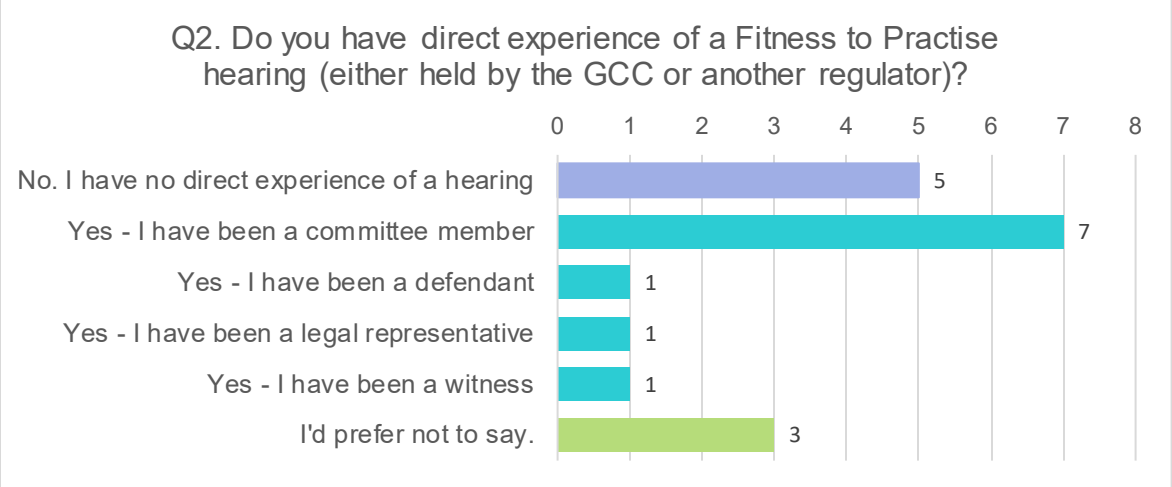
We received 14 completed consultation responses through the consultation form. A further 4 incomplete responses were included as they had completed the majority of the survey (they did not complete the EQWLIA question or the diversity monitoring).

Three organisations responded directly (via letter) to the consultation.

In total we considered 21 responses: 14 from individuals, and 7 from organisations.



Note: Two individuals (one chiropractor and one patient) answered this question twice - highlighting their role while also responding on behalf of an organisation.



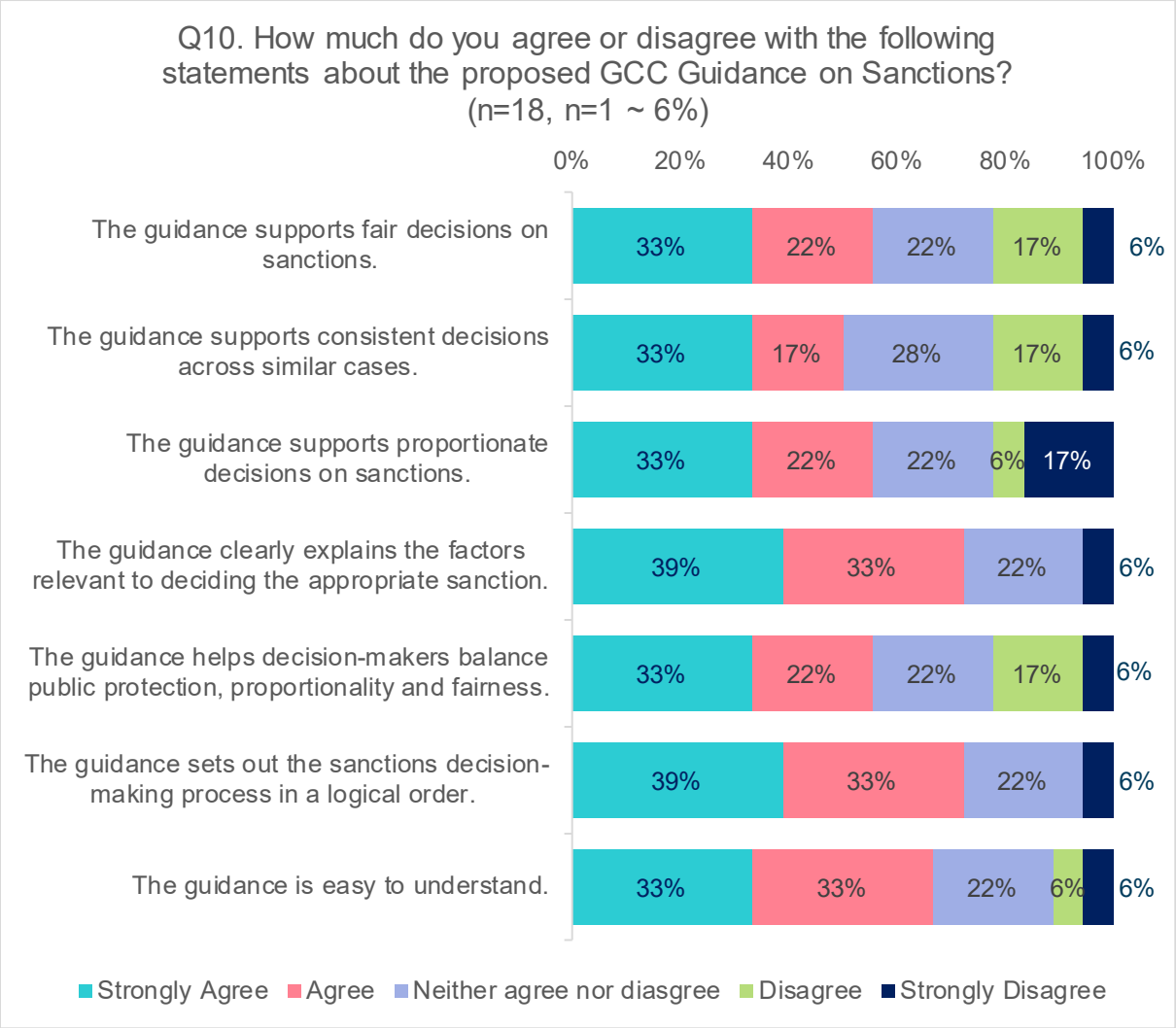
Further information on the demographics of respondents is available in appendix 2

We received organisational consultation responses from:

- British Chiropractic Association
- Capsticks Solicitors LLP (GCC counsel)
- Chiropractor Patient Voice
- Cura Law Limited (responding in conjunction with the United Chiropractic Association)
- General Medical Council
- Professional Standards Authority
- Royal College of Chiropractors

Quantitative analysis of responses

Individuals

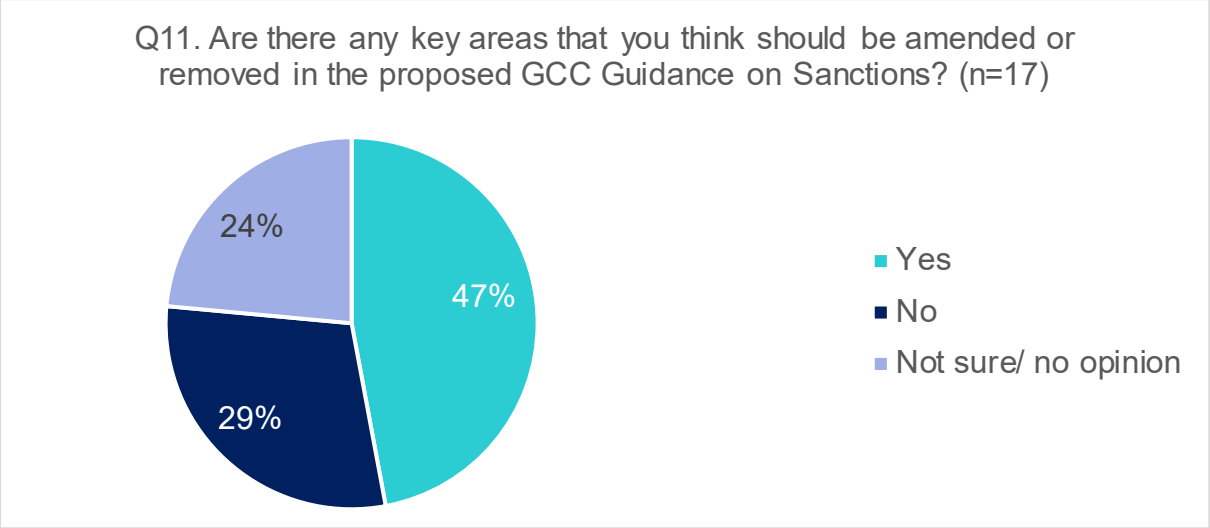


At least half of responding registrants agreed ('Strongly agree' or 'agree') with all statements at Q10, while less than a quarter disagreed ('Strongly disagree' or 'disagree') with each statement, and approximately a quarter chose to neither agree nor disagree throughout.

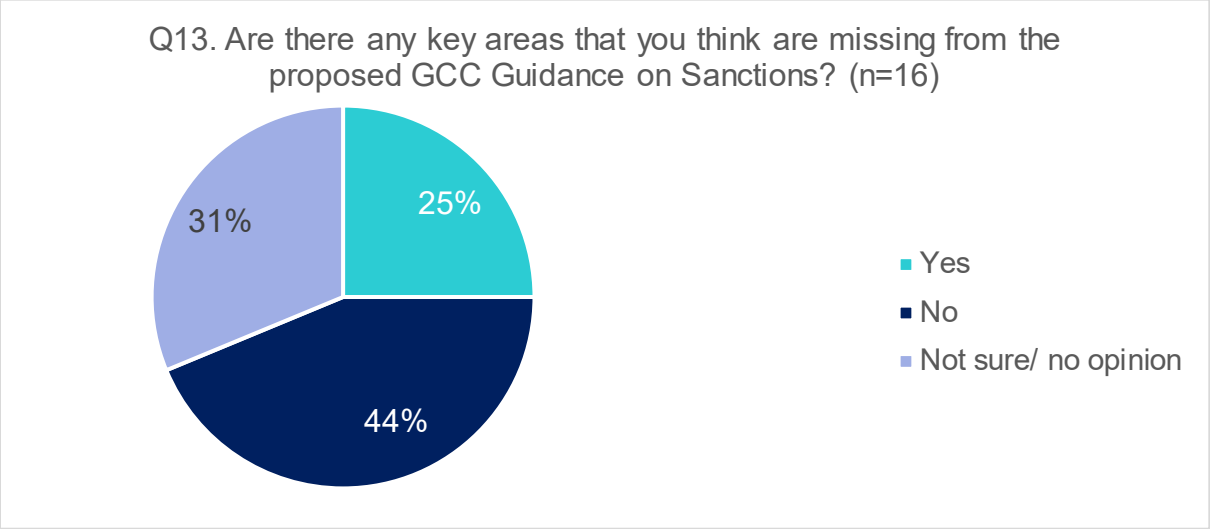
There were notable increases in agreement with statement 4 "The guidance clearly explains the factors relevant to deciding the appropriate sanction", statement 6 "The guidance sets out the sanctions decision-making process in logical order", and statement 7 "The guidance is easy to understand".

The lowest agreement was for statement 2 "The guidance supports consistent decisions across similar cases" with slightly more respondents selecting 'neither agree nor disagree' at this statement, likely due to the more hypothetical nature of the statement.

Overall, responses suggest that registrants were more likely to agree with statements that focussed on the content and structure of the guidance rather than its application and outcome.



As expected from a consultation, most respondents felt that there are key areas that should be amended or removed from the guidance (Q11). Their reasons were explored further in the question that followed (analysed below).



A quarter of respondents felt that key areas were missing from the guidance (Q13). Their reasons were explored further in the question that followed (analysed below).

Organisations

Of the four organisations that completed the consultation survey, the Professional Standards Authority remained neutral by selecting “neither agree nor disagree” for all the statements in Q10. Two of the remaining three organisations “agreed” or “strongly agreed” with the first five statements in Q10 (the fourth “neither agreed nor disagreed”). All three organisations agreed that “The guidance sets out the sanctions decision-making process in a logical order” (Q10.6) and “The guidance is easy to understand” (Q10.7).

General feedback from response comments.

In general, the guidance was received positively, with respondents recognising the importance of the Guidance on Sanctions as a tool to protect to the public.

> A worthwhile consultation to update the Guidance on Sanctions.
>
> **Comment from a patient**

> The proposed Guidance on Sanctions is a significant improvement on previous versions and provides a clear, transparent, and structured framework for decision-making. We welcome the emphasis on public protection, proportionality, consistency, insight, remediation, and the recognition that cultural, linguistic, and health-related factors may influence how registrants engage with regulatory processes.
>
> **Comment from a professional association**

> We particularly welcome the emphasis on proportionality and on identifying the minimum sanction necessary to protect the public, together with the clearer explanation of the factors that should inform that decision.
>
> **Comment from a standards setting organisation**

Generally, they were thought to be clearly set out, with a clear and logical approach.

> Overall, we consider the guidance to provide a clear and logical framework for determining sanctions. It supports fair and consistent decision-making, while appropriately recognising that each case must be considered in light of its individual circumstances.
>
> **Comment from a standards setting organisation**

> The proposed Guidance on Sanctions is generally well structured and provides greater clarity regarding the graduated approach to sanctions, the importance of public protection, and the role of insight and remediation in decision-making.
>
> **Comment from a professional association**

> We do not suggest that any major areas should be removed. Overall, the proposed guidance appears to set out a helpful and logical framework for decision-makers.
>
> **Comment from a regulator**

though one registrant suggested that they were confusing and highlighted the need for clarity.

> … they are confusing and they should be able to be understood with ease.
>
> **Comment from a registrant (16 - 20 years)**

Along with constructive criticism of the proposed document (considered below) there was also general comment on the Fitness to Practise process.

> [The] process is far too expensive and very adversarial, there is a completely disproportionate response to Relatively Trivial infractions…
>
> **Comment from a registrant (over 20 years)**

> …we should be moving towards a no blame learning culture Not an adversarial expensive culture which is fundamentally quite parasitic
>
> **Comment from a registrant (over 20 years)**

While the frustration with the process is understandable, the need for a more proportionate approach to Fitness to Practise was identified within the General Chiropractic Council Strategy 2026-2030, and work is already underway to address many of the concerns raised.

While these planned changes are intended to create a more proportionate and timely system, there will still be cases that are so serious as to require a sanction, and this document needs to be seen within the context of the whole Fitness to Practise system.

To frame that context more clearly, page 2 of the guidance now specifically highlights the context, and all the relevant primary and secondary legislation, the GCC publication schedule, protocol for hearings document and practical arrangements for remote hearings document are included on the references page.

Specific themes from qualitative analysis.

These themes are presented in the order they appear in the revised guidance. Comments reference the paragraph numbers in the consultation edition.

Welsh Language

There were no Welsh language responses to the consultation, however there were comments relating to the use of the Welsh Language.

> In addition, consideration should be given to the potential impact of language on the assessment of insight, reflection, remorse, and communication during regulatory proceedings, particularly where Welsh is an individual's first language. Ensuring appropriate linguistic support and cultural awareness may help promote fair and consistent decision-making.
>
> **Comment from a professional association**

Most comments relating to the Welsh Language were relevant to the assessment of the guidance in the EQWLIA, or addressed practical issues within the FTP process (and not decision making on appropriate sanctions). We do, however, acknowledge that there was a need to specifically address that a committee will provide support to use Welsh, and that no adverse conclusion should be drawn by the committee from the use of Welsh. This is addressed in paragraph 7.

Admonishment as a minimum sanction

One legal counsel highlighted that the Act requires a sanction if an allegation is well founded.

> The GCC may wish to confirm that there is no option for taking ‘no further action’ if an allegation is found well founded (and in the case of conviction also materially relevant). I.e. at a minimum the PCC will impose an admonishment
>
> **Comment from legal counsel**

Paragraph 25 has been added to clarify this.

Submissions

A strong theme emerging from responses to the consultation, and during the Quarterly Defence Meeting, was whether the GCC should present an expectation of a sanction. This was a change from the previous guidance.

> We submit that the previous guidance should be retained and that the GCC should not make submissions advocating any particular sanction. The GCC is an independent and impartial regulator. Its role is not to prosecute a registrant or to seek a particular punitive outcome, but to place the relevant evidence before the committee so that the committee can make findings and, where an allegation is well founded, exercise its own judgement as to sanction. Once the evidential and fact-finding stages have concluded, it should be for the committee alone to determine whether a sanction is necessary and, if so, the least restrictive sanction required to meet the overarching objective. Permitting the GCC case presenter to recommend a particular outcome would risk changing the character of the sanctions stage from independent regulatory decision-making into an adversarial contest between competing sanction bids.
>
> **Comment from a professional association**

> There is no need for the GCC to make submissions on the law, the committee's statutory purpose or the range and effect of the available sanctions. The committee is assisted by a legal assessor, whose function includes advising it on these sanctions and the need to give adequate reasons. The committee also has the sanctions guidance itself. The existence of that independent legal assistance is an important safeguard and removes any justification for the GCC case presenter to assume an advisory role or to contend that a particular sanction should be imposed.
>
> **Comment from a professional association**

Following consideration paragraph 26 has remained unchanged.

The staged approach to decision making (paragraphs 17 to 23) separates the decision of UPC from the decision of which sanction is the minimum necessary to protect the public. Once impairment or UPC is decided, there is no option not to apply a sanction. The GCC is not an outlier among health regulators in making a submission at this stage, and it will clarify for the chiropractor the sanction that the regulator considers appropriate in light of the need to protect the public, maintain public confidence and uphold professional standards.

The paragraph makes it clear that the submissions from both the GCC and chiropractor are not binding on the committee and both are intended to assist the independent committee.

One comment highlighted that the Medical Practitioner Tribunal Service publishes a matrix of sanctions bandings for case types commonly seen at hearings. The GCC will consider if producing similar guidance would be of assistance.

Appeals

One professional association sought assurance that the right to appeal a decision of the Health Committee remained. It was inadvertently omitted from the overview of the available sanctions, while remaining in later sections. Paragraph 38 been amended in the final version.

> Proposed paragraph 33 states that a chiropractor has a right of appeal within 28 days against any decision of the PCC, but does not refer to decisions of the Health Committee…
>
> … The GCC should confirm that the omission in paragraph 33 is inadvertent and amend it to state the appeal position for both the PCC and HC clearly and consistently.
>
> **Comment from a professional association**

Conditions Bank

One FTP committee member asked for clarification of the role of the conditions bank. This is added at paragraph 52.

> At para 47, confirm that the bank of conditions is not exhaustive. Current language is that panel should refer to the bank. Might be helpful to include that panel is not limited to these conditions.
>
> **Comment from a lay member of FTP committee**

Conditions of Practice Order

While responses from professional associations felt that greater prominence should be given to whether proposed conditions of practice should be workable:

> The proposed guidance should give greater prominence to whether conditions are workable in the realities of chiropractic practice, particularly for sole practitioners and chiropractors working in small clinics. Conditions dependent upon workplace reporting, formal supervision or access to a particular type of reviewer may be impossible to satisfy in practice and can operate as a de facto suspension.
>
> The committee should be required to consider availability, cost, geographical practicality, confidentiality, the proposed supervisor's role, how compliance will be evidenced, and whether the wording is sufficiently precise for both the chiropractor and the GCC. Where a workable condition cannot be formulated, the committee should explain why. Conversely, a condition should not be rejected merely because due to administrative arrangements.
>
> **Comment from a professional association**

Others suggested that the proposed guidance gave this too much prominence:

> In our experience Panels (including across Regulators) have taken different approaches in relation to the 'workability'. For example, an inability to currently source a supervisor may be seen as evidence of the 'unworkability' of conditions or the conditions providing the appropriate level of restrictions based upon the current availability of a supervisor.
>
> **Comment from legal counsel**

> The proposed guidance appears to place considerable weight on the registrant's own views about whether conditions would be workable. Whilst the registrant's submissions may be relevant, there is a risk that the drafting could encourage committees to give disproportionate weight to submissions that conditions are impracticable or unworkable.
>
> **Comment from a regulator**

Paragraphs 53 and 54 remains unchanged. While the GCC is alive to the challenges facing chiropractors working alone or otherwise unable to access supervision, the overarching objective must be to protect the public. We consider that a lesser or greater sanction than that which is necessary to protect the public should not be imposed simply because certain conditions may not be supported by a specific person or body.

Duration of a sanction

The proposed guidance was felt by some to not include sufficient detail on the length of time of an order (suspension or conditions of practice)

> The document explains the available maximum periods but gives limited assistance on selecting the length of a Conditions of Practice or Suspension Order. It should state that duration must be reasoned and linked to the purpose of the order. Relevant considerations include the time realistically required to complete remediation, obtain evidence, undertake treatment, demonstrate sustained change and arrange a fair review.
>
> **Comment from a professional association**

> Committees should avoid selecting conventional or rounded periods without explaining why that period is necessary. They should also consider whether an order's duration…creates a disproportionate overall restriction.
>
> **Comment from a professional association**

> The GCC may wish to include the maximum time periods for each order in the summary box (as well as in the text in subsequent sections)
>
> **Comment from legal counsel**

The maximum duration has been added to paragraph 35. The Guidance has been expanded to explicitly require the panel to explain why the duration of a sanction is necessary (paragraphs 32, 56, and 68-70).

Removal Order

One respondent highlighted that Parliament had established a statutory definition of "fundamentally incompatible" in relation to regulation as a health professional within the AAPA Order (2024).

> We have moved away from describing conduct as 'fundamentally incompatible' with registration in the MPTS guidance. Under Article 9(1)(c) of the AAPA Order 2024, Parliament established automatic removal thresholds for specified listed offences. We consider that this statutory threshold defines what is 'fundamentally incompatible' and therefore we now describe removal / erasure as being as being action that is available 'where a doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is incompatible with continued registration at this point in time. It means the level of current and ongoing risk the doctor poses to public protection is so significant that they should not be allowed to practise.'
>
> **Comment from a regulator**

While this definition is not yet within the legislative framework for chiropractors, it has been included within paragraph 82 of the guidance as an example of the level of conduct that is likely to lead to a removal order.

Reckless and deliberate conduct

There were a number of comments relating to the recklessness and deliberateness of the conduct and the extent to which a chiropractor should foresee the degree of risk.

> We support the recognition that reckless disregard for patient safety, or a fundamental failure to protect patients from harm, should be regarded particularly seriously.
>
> **Comment from a standards setting organisation**

> The extent to which the harm was deliberate and/or reckless could also be highlighted.
>
> **Comment from legal counsel**

This has been strengthened in paragraphs (90 and 91).

Assessing written and oral evidence of insight and remediation

A number of comments related to the difficulty of assessing evidence, and the importance of guidance in how to interpret different forms of evidence.

> Assessing insight and reflective material
>
> The guidance could be strengthened by recognising the limitations of written reflections when assessing insight. The PSA's guidance on accepted outcomes, highlights the challenges in assessing insight on written evidence alone in difficult or complex cases, particularly where there may be serious or fundamental attitudinal issues, or where registrants may have received significant support producing reflective statements or used AI.
>
> We suggest that the sanctions guidance should encourage committees to consider the quality, authenticity and depth of insight, rather than the existence of a reflective statement alone. Where insight is central to the decision on sanction, and particularly where the case involves serious misconduct, attitudinal concerns, discrimination, exploitation or abuse of trust, the committee may need to test insight through oral evidence or other reliable evidence.
>
> **Comment from a regulator**

The proposed guidance recognised that the way a chiropractor expresses themself may be affected by their cultural background, neurodiversity or other factors. This was welcomed, but some comments felt it could be expanded further.

> Re para 93, excellent to include cross-cultural implications for displaying insight. Reference should also be made to any relevant literature on gendered differences in this regard.
>
> **Comment from a lay member of FTP committee**

> We welcome the recognition that insight and expressions of remorse may vary across cultures and individuals. However, the assessment of insight remains inherently subjective. Additional practical examples or case studies illustrating poor, developing, and good insight may assist Committees in applying this aspect of the guidance more consistently.
>
> **Comment from a professional association**

The guidance has been reorganised to separate assessing insight and remediation evidence (paragraph 95-101) including the strengths and challenges of written and oral evidence. The importance of corroborating evidence in cases where testing insight is a significant factor is considered in paragraph 107.

The role of apology and the duty of candour

A related consideration is the role and timing of an apology in demonstrating insight. The Duty of Candour expects that a chiropractor will apologise to a patient when something goes wrong with the care (Standard C11 of the Code of Professional Practice) and it is established (though not always recognised by chiropractors) that an apology is not an admission of guilt or liability.

An early apology may prevent a concern being raised with the GCC and can demonstrate insight into what went wrong (and how to remediate it) without a chiropractor believing that the conduct amounted to UPC.

> The draft guidance could make clear that committees should consider whether there is evidence that the timing or absence of an apology was influenced by factors outside the registrant's control, such as organisational governance arrangements, advice received during ongoing litigation, or the culture within their workplace. In these circumstances, committees should avoid drawing adverse inferences solely from a delayed or absent apology without first taking those contextual factors into account.
>
> Including this additional explanation would assist committees in assessing the evidential weight to be attached to an apology, or the absence of one, while maintaining the focus on whether the apology demonstrates genuine insight and remediation.
>
> **Comment from a regulator**

In response we have expanded the section considering apologies (paragraphs 102-104) and added an explicit direction that an apology is not an admission of facts alleged or current impairment (paragraph 104).

The extent of insight and remediation

The ability to remediate (particularly when conduct is behavioural or attitudinal); the extent of insight and remediation; and how to measure remediation were all discussed by respondents.

> We welcome the emphasis placed upon insight and remediation. Decisions on sanctions should appropriately recognise chiropractors who identify shortcomings, reflect upon them, undertake relevant education or training and demonstrate that changes have become embedded in their practice. The draft recognises that successful learning or training may provide evidence of remediation in cases involving professional competence.
>
> **Comment from a standards setting organisation**

> Insight and remediation are addressed in general terms in the guidance but in terms of its application to specific types of cases, only dishonesty is addressed specifically in this regard (Para 136). Some misconduct, such as sexual misconduct, is also hard to remediate, as it is behavioural by nature and as such insight and remediation are fundamental. It is important that panels are given some guidance to assist them in assessing genuine insight and remediation in light of such cases which is an area of concern that we see in reviews of decisions.
>
> **Comment from a regulator**

Paragraph 107 now points to examples where insight may be central to a decision on sanction and suggests that insight should be tested across evidence.

Further guidance on the ability to remediate was added to paragraphs 113, 175 and 180.

The tension between defending an allegation and demonstrating insight

A number of comments highlighted that the right to contest an allegation should not count against a chiropractor when their insight was assessed ahead of applying a sanction.

> The assessment of insight should focus on the chiropractor's response to the findings actually made once those findings are available. Admissions may be relevant, but early admission should not become the only reliable marker of insight. A chiropractor may accept and address identified risks without adopting every aspect of the GCC's case or the complainant's account. This safeguard is particularly important because findings may involve mixed conclusions, nuanced clinical judgements, or only part of an allegation being proved.
>
> We submit that the guidance should contain a standalone principle confirming that exercising the right to contest an allegation or appeal a decision is not, without more, evidence of a lack of insight. This is sufficiently important that it should not be left to implication within the wider discussion of insight and should be explicitly covered.
>
> **Comment from a professional association**

While we disagree that insight should focus on the chiropractors response after a finding of fact (see comment on apologies and the Duty of Candour), we acknowledge that tension exists between the right to contest allegation and the demonstration of insight.

> A registrant must remain free to contest allegations and exercise appeal rights without that being treated as an aggravating feature on its own. Committees should focus on the findings actually made and give proper weight to objective remediation, safe practice, audit, supervision and behavioural change.
>
> **Comment from a professional association**

In response we added a sentence acknowledging the tension (paragraph 109).

Previous regulatory concerns

The role of previous regulatory findings in respect of demonstrating repetition of behaviour was felt to be insufficiently clear:

> The GCC may wish to provide greater clarity in relation to the definition of 'adverse findings' i.e. findings at Facts or UPC. We would anticipate the Defence adopting the stance that a finding can only count if it is 'well founded' but note that this could lead to situations where a Registrant has committed similar conduct but that conduct in isolation has not crossed the threshold for UPC, but a later (and more serious) repetition is then adjudicated without the full context.
>
> **Comment from legal counsel**

This was clarified in paragraph 119 and 120.

References and testimonials

The professional associations both commented on the role of references and testimonials in the guidance.

> The guidance appropriately cautions against placing undue reliance on character references. However, it may be helpful to provide further direction on the circumstances in which testimonials can meaningfully demonstrate remediation, behavioural change, or current professional practice, particularly where concerns relate to competence rather than character.
>
> **Comment from a professional association**

With one suggesting that requiring the attendance of a reference is unhelpful.

> The principal questions should be authenticity, the author's knowledge of the findings, the basis and duration of their knowledge of the chiropractor, and relevance to risk, insight, remediation or professional standing. Attendance could be one possible consideration, but not a prerequisite for meaningful weight. The express statement that no adverse inference should be drawn from the absence of testimonials is welcome and should be retained.
>
> **Comment from a professional association**

These areas of the guidance have not been materially changed. Testimonials at the sanction stage are predominantly concerned with issues of character (questions of remediation and competence are better addressed through evidence and expert witnesses).

The question of attendance is required to ensure that the evidence can be further explored by the committee (including through an online meeting) if required.

Unrepresented chiropractors

> The proposed guidance contains no specific provision addressing cases in which a chiropractor is unrepresented. Unrepresented registrants may be at a particular procedural disadvantage when addressing sanction. They may not understand the distinction between evidence and submissions, the ascending approach to sanctions, the significance of insight and remediation, the types of evidence likely to assist, or the practical implications of conditions, suspension, removal and review. These difficulties may be compounded by ill health, disability, neurodiversity, language needs, financial constraints or the stress of the proceedings. The absence of focused submissions or supporting evidence should not therefore be treated automatically as an absence of insight, remediation or relevant mitigation.
>
> **Comment from a professional association**

We agree that there was a need to specifically address proceedings when a chiropractor does not have a legal representative – how they would be supported to participate in proceedings and that no adverse conclusion should be drawn by the committee.

Considering previous interim suspension orders

There was discussion of the relevance of "time spent" under an interim suspension.

> Committees …should also consider whether an order's duration, together with time already spent under an interim order, creates a disproportionate overall restriction.
>
> **Comment from a professional association**

The GCC considers that an interim suspension order is not a sanction – it serves a fundamentally different purpose (immediate protection of the public) to the imposition of a suspension or conditions of practice order, and it is not appropriate to give this time undue weight when imposing a sanction.

In this aspect the GCC is in agreement with the following comment:

> We endorse the stance that time spent under an interim order (such as an interim suspension) should not automatically be deducted from a substantive sanction on the basis that interim orders and substantive sanctions serve fundamentally different statutory purposes.
>
> **Comment from a regulator**

However, we also note that this may not apply in cases that purely focus on public confidence (not protection):

> You may also wish to consider the case of Kamberova v Nursing and Midwifery Council [2016] which establishes that time spent under an interim suspension remains nevertheless a factor to consider when evaluating overall proportionality in cases engaged purely on public confidence grounds.
>
> **Comment from a regulator**

In response the relevant paragraphs (128-130) have been redrafted to be clearer with references to the relevant caselaw.

Mitigating and Aggravating factors

There was some criticism that this section was underdeveloped – particularly highlighting a need for deeper consideration of systematic issues and duress as mitigation:

> …further consideration could be given to the influence of workplace, organisational, and system-level factors on professional conduct and performance. This may be particularly relevant in cases involving workload pressures, inadequate support structures, communication failures, or other contextual factors that contribute to concerns.
>
> **Comment from a professional association**

> Paragraph 81 of the 2018 guidance expressly identified that a chiropractor was acting under duress as one of the non-exhaustive factors which might support an admonishment. That factor has been omitted from the equivalent list in proposed paragraph 36, without explanation.
>
> **Comment from a professional association**

> The Guidance identifies as potential mitigation "any evidence of wider systemic issues in the workplace" (paragraph 110 (e), page 21). However, there is little practical guidance for Panels on how workplace factors should be assessed.
>
> While systemic factors will not excuse unacceptable conduct, they may assist committees in understanding how concerns arose and in assessing risk of repetition, remediation and proportionality. This is also an area that has received increased focus in the context of understanding the causes of major failures of care. It may therefore it may be helpful to provide more guidance for committees on how to identify and account for factors such as inadequate supervision, staffing pressures, organisational failures, ineffective governance arrangements, poor workplace culture or deficient training arrangements.
>
> **Comment from a regulator**

It was considered that an allegation being found proven in circumstances where a registrant has acted under duress was so rare that it is not helpful to identify it as a factor.

The wording does not prevent a committee considering duress (the document is guidance) but does not encourage the committee to look specifically for evidence of duress where it would be more productive to consider wider systemic issues (that would include duress).

The assessment of systemic issues has been expanded in paragraph 138.

Particular Categories of Case

Convictions

One respondent highlighted a need for clarity in the definition of a conviction within the guidance.

> Paragraph 116 … defines a "conviction" as a finding of guilt by a criminal court "anywhere in the world". That does not reflect the wording of section 20(1)(c) of the Chiropractors Act 1994, which refers to a chiropractor having been convicted in the United Kingdom of a criminal offence. The previous guidance correctly described convictions for this purpose as findings of guilt by a criminal court in the United Kingdom.
>
> **Comment from a professional association**

Paragraph 144 now accurately reflects the wording of the Act. Paragraphs 145 (out of court disposals) and 146 (overseas convictions) deal with other findings of criminal conduct as UPC.

Conditional discharges

We note a comment concerning the status of conditional discharges.

> We are concerned that proposed paragraph 117 omits the express clarification in paragraph 56 of the 2018 guidance that a conditional discharge does not constitute a conviction under English law. The earlier paragraph distinguished conditional discharges, cautions and penalty notices, while explaining that cautions or penalty notices might nevertheless amount to unacceptable professional conduct. The proposed paragraph 117 retains the points concerning cautions and penalty notices but gives no explanation for deleting the conditional-discharge provision.
>
> **Comment from a professional association**

The test of a conditional or absolute discharge (Paragraph 152) is now its material relevance, not its existence.

Alcohol related convictions

Paragraph 153 was added in response to the following comment.

> The GCC may wish to include some comment in relation to alcohol related convictions (given that these are by far the most common). The stance taken by panels in previous decisions is that convictions for drunk driving are likely to be materially relevant but seriousness will be fact specific.
>
> **Comment from legal counsel**

Sexual Misconduct

Further changes were made to this section to strengthen the connection to the standards within the Code of Professional Practice and Guidance for Registrants on professional boundaries – particularly concerning the motivation of sexual misconduct (and that it does not need to be sexually motivated).

> Serious safeguarding and boundary-related misconduct
>
> The previous version of the guidance contained more detailed reference to serious child safeguarding concerns including child sexual exploitation, while the revised version appears to contain only brief mention. Given the seriousness of such conduct for public protection and public confidence, the guidance should support panels to identify where this type of behaviour may require a more restrictive sanction and to give clear reasons for any sanction imposed.
>
> **Comment from a regulator**

The guidance now specifically lists child sexual abuse material (paragraph 160) and also explains that any conduct leading to a chiropractor being placed on the Sex Offenders Register, Children's Barred List or Adult's Barred List is also likely to be regarded as particularly serious. (paragraph 164).

Failing to provide an acceptable level or treatment or care

A standards setting organisation highlighted that the paragraph highlighting clinical failings as a category of case where serious action is likely to be required did not fully explore the spectrum of clinical failing.

> We support the recognition that reckless disregard for patient safety, or a fundamental failure to protect patients from harm, should be regarded particularly seriously.
>
> … Given that clinical practice and professional competence are areas in which remediation may be particularly relevant, this section could usefully provide greater guidance on different types and degrees of clinical failing.
>
> … Greater recognition of this spectrum could assist committees in assessing the seriousness of the failing, future risk, remediation and proportionality, while maintaining patient protection as the overriding consideration.
>
> **Comment from a standards setting organisation**

They further highlighted that lack of insight should not be the only aspect of failure in clinical practice that added to the seriousness of the failing – and other aspects should be considered as part of the sanction consideration.

> In this context, we suggest some caution around paragraph 138, where a lack of insight appears to suggest that removal from the register may be the appropriate sanction. Lack of insight should be considered alongside the nature and seriousness of the failing, clinical risk and objective evidence of competence, rather than serving as the sole determining factor.
>
> **Comment from a standards setting organisation**

While we agree that clinical practice is a spectrum, the test of UPC or professional incompetence is a high bar which will "filter out" cases at the lower end of that spectrum.

The guidance on the importance of insight when setting sanctions for clinical failings is therefore appropriate. We recognise that clinical failings may be addressed through training or other learning, and paragraph 180 has been expanded to include this.

Discrimination and harassment

Respondents welcomed the inclusion of discrimination and harassment in the proposal but felt it needed more detail.

> The recognition of discrimination, harassment and victimisation as serious concerns is appropriate. However, further clarification would be helpful regarding how isolated incidents, unconscious bias, systemic factors, and deliberate discriminatory conduct should be differentiated when assessing sanction. This would support greater consistency and proportionality in decision-making.
>
> **Comment from a professional association**

> We welcome the proposed inclusion of discrimination in the sanctions guidance. However, we consider that more detail is needed to support committees in addressing this type of misconduct as is provided for dishonesty and sexual misconduct. …
>
> We suggest that the guidance should explain why discriminatory conduct may be particularly serious in a healthcare context, including because of its potential impact on patients, colleagues, public confidence and confidence among groups who may already experience barriers to accessing care. The guidance could also explain how discriminatory conduct may be relevant to insight, remediation, attitudinal concerns and risk of repetition. This would help avoid discrimination being treated only as a generic aggravating factor, without sufficient analysis of its nature, impact and seriousness.
>
> This is particularly important in the context of the Lord Mann Review and the findings from recent maternity reviews such as the Nottingham Independent Review and the Independent investigation into maternity and neonatal services in England (the Amos Review) which identified the patient safety implications of discrimination.
>
> **Comment from a regulator**

The guidance now contains more detail (paragraphs 181-189) including the consideration of discrimination which may not meet the legal threshold of being unlawful and analysis of its seriousness and impact.

Exploitation of vulnerability and victimisation

Similarly, the importance of vulnerability and victimisation was felt to need further detail.

> The guidance would benefit from more explicit discussion of vulnerability and how it should be taken into account when determining sanction. Vulnerability may be relevant to seriousness, culpability, harm, risk of repetition, public confidence and whether a particular sanction is sufficient to protect the public. It may also be relevant where a registrant has exploited, failed to recognise, or failed to respond appropriately to a patient's circumstances.
>
> We suggest that the guidance should make clear that vulnerability is not limited to fixed personal characteristics. It may arise or be increased because of the patient's health, the nature of care being provided, barriers to raising concerns, dependency on the practitioner, communication needs, previous experiences of harm, or the stress of participating in a fitness to practise process.
>
> **Comment from a regulator**

This was addressed in a new section paragraphs 190 to 196.

Paragraph 195 (which discusses inappropriate relationships which are not necessarily sexual) was added in response to the comments relating to specific targeting of vulnerability by a chiropractor:

> We suggest the guidance should address inappropriate relationships that are not necessarily sexual in nature. This has been an issue that the PSA has previously raised in learning points arising from our review of a previous case under our section 29 powers in relation to the distinction drawn by a panel between romantic and other boundary-related conduct, and noted that the GCC's guidance could be strengthened in this area. The guidance also doesn't touch on how sexual harassment might differ from other kinds of sexual misconduct.
>
> **Comment from a regulator**

> Rather than framing professional boundary breaches as a standalone case type, you will see that we incorporate boundary guidance directly into specific case categories like dishonesty and sexual misconduct where it is often a common feature. However, we treat predatory behaviour as a feature that increases seriousness across all types of allegations, encouraging decision-makers to evaluate it broadly. As this approach encourages decision-makers to assess the individual circumstances of every case, you may consider there is a benefit to taking a similar approach.
>
> **Comment from a regulator**

Review hearings

The guidance should provide clearer and more consistent information about what a chiropractor is expected to demonstrate at review. The original committee should identify, without improperly binding the reviewing committee:

- the concerns which remain outstanding;
- the purpose of the order;
- the evidence likely to assist a future review;
- any training, reflection, audit, supervision or medical evidence that may be relevant; and
- the criteria by which compliance and remediation can fairly be assessed.

This would make orders more effective and reduce the risk that a chiropractor reaches a review without understanding what evidence is required. Any suggested evidence should remain proportionate and realistically obtainable.

Comment from a professional association

We consider that some guidance on the approach to be taken when there has been a breach of conditions (including the evidence that could be relied upon) likely to be helpful.

Comment from legal counsel

The GCC may wish to comment on the weight /significant of any comments made by a substantive panel on the reviewing panel (not binding, but likely to be a starting point for consideration given the substantive panels involvement with the underlying evidence at the hearing).

Comment from legal counsel

On reflection, the draft guidance did not adequately separate the responsibilities of the committee issuing a sanction from the responsibilities of the committee hearing the review.

The committee issuing the sanction must consider a review and ensure the review hearing is properly informed. Their responsibilities are (where appropriate) stated with each sanction (e.g. paragraphs 59-62).

The staged approach and guidance for a Review Hearing committee is now within a new section starting at paragraph 197.

Interim Suspension Orders

On reflection it was important to further highlight the separation of an interim suspension order imposed before a finding of fact (e.g. paragraphs 128-130) (see also considering previous suspension orders) from an order imposed to prevent harm during the appeal period after a sanction is imposed.

There were differences in opinion on whether an interim suspension order should automatically follow a suspension or removal order.

One professional association argues against a presumption of interim suspension:

> Paragraphs 150–152 should more clearly preserve a separate and reasoned decision on interim suspension. The imposition of suspension or removal does not of itself answer whether immediate suspension during the appeal period is necessary. The guidance should require the committee to identify the specific risk that makes an interim order necessary, consider whether any less restrictive protection is available, address relevant submissions, and give separate reasons.
>
> **Comment from a professional association**

> The statement that a chiropractor should have had sufficient time to plan for an interim order risks appearing to predetermine the practical-impact assessment. Notice of a hearing does not mean that a chiropractor could reasonably know that an adverse finding, removal or immediate suspension would follow. That passage should be removed.
>
> **Comment from a professional association**

Whereas others felt it was illogical to continue to allow practice during an appeal.

> The guidance states that a panel will consider an interim order after imposing a removal order. In our view it should be clear that in most cases this will happen, as if the decision has been taken to remove it is illogical to allow them to return to practise for a period (which may be lengthy in the case of an appeal). This is a concern we have previously identified through our oversight.
>
> **Comment from a regulator**

It does not automatically follow in the Act that an ISO will follow a removal or suspension order, and so the guidance now makes that clearer (paragraph 221) while also placing more expectation that an ISO will always be considered (e.g. paragraphs 84-86).

Health committee

Discussion with the registrant health working group highlighted the importance of separating the condition (whether physical health, mental health, neurodiversity, or addiction) from the insight into the impact of the condition and the ability to manage or use accommodations to mitigate that impact.

As an example, a condition with a potentially serious impact can be well managed and cause no concern, while a relatively more mild condition can cause an impairment if the chiropractor lacks insight and it is therefore not effectively managed.

The GCC is actively working to strengthen our guidance elsewhere in taking this approach, and will work with the registrant health working group to that end.

However, we do not believe the Guidance on Sanctions is the appropriate place for this. The Guidance is likely to assist the Health Committee when the chiropractor lacks insight into a condition, is therefore unwilling or unable to manage the condition appropriately, and this is impairing their ability to practise safely.

In these cases, it is appropriate to impose a sanction to protect the public, and so the guidance in the proposal remains broadly unchanged.

Comments on the Equality and Welsh Language Impact Assessment

The Equality and Welsh Language Impact Assessment (EWLIA) is intended to consider how the guidance may impact issues of equality, diversity and inclusion, and issues relating to the use of the Welsh language.

We were pleased that the consultation received a greater level of comments than EWLIAs in previous recent consultations.

> Yes, overall the Equality and Welsh Language Impact Assessment appears to appropriately identify many of the potential equality considerations associated with the proposed guidance, particularly in relation to culture, language, disability, and the assessment of insight and remorse.
>
> **Comment from a professional association**

> We welcome the sanctions-specific assessment and its recognition of several positive impacts, including clearer decision-making, stronger treatment of discriminatory and sexual misconduct, a focus on ability to practise safely rather than the mere existence of a health condition, sensitivity to cultural and linguistic differences, and protection against adverse inferences where testimonials are absent.
>
> **Comment from a professional association**

The constructive comments received can be broadly categorised into three groups.

- Comment on the guidance itself (from the point of view of EDI and Welsh)
- Comment on the EWLIA assessment process and document
- Comment on wider issues within the PCC and HC process (from the point of view of EDI and Welsh).

Comment on the guidance itself (from the point of view of EDI and Welsh)

Specific changes that have been made to the guidance where issues of EDI or Welsh were raised (and acknowledged) have already been addressed above, and include:

- Welsh language
- Assessing written and oral evidence
- Unrepresented chiropractors

There are also substantial new sections considering discrimination and harassment (including on the basis of protected characteristics) and exploitation of vulnerability and victimisation (where a power imbalance related to a protected characteristic is often a factor).

Comment on the EWLIA assessment process and document

There was some comment that the conclusions of the EWLIA were too generalised and did not logically follow the findings of the EDI Thematic Review of the Professional Conduct Committee carried out in 2024.

> However, its conclusion that the guidance will have no detrimental impact on people with protected characteristics is too categorical. It is difficult to reconcile with the assessment's own evidence of possible disparities: disabled chiropractors had a slightly higher proportion of UPC findings in the small sample reviewed, while female chiropractors received proportionately more suspensions and conditions once UPC was found. Although the datasets are small, these are potential risks requiring qualitative review, monitoring and mitigation—not a conclusion that no adverse impact exists.
>
> **Comment from a professional association**

Both the guidance, and the equality impact assessment have benefitted substantially from the consultation comments relating to equality, diversity and inclusion.

For each protected characteristic the EWLIA now assesses two impacts – the impact on registrants (and other participants in the PCC and HC process), and the impact on patients and the public resulting from sanctions being imposed by the policy.

The assessment also better explains the limitations of the available evidence, and the importance of continuing to monitor the process and review the impact of the guidance.

Comment on wider issues within the PCC and HC process (from the point of view of EDI and Welsh)

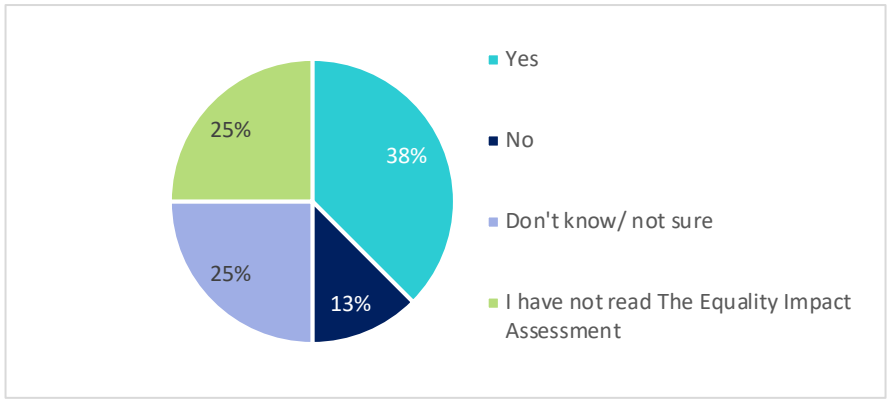
We considered some comments to be out of the scope of the Guidance on Sanctions. For example,

> We suggest that the following areas within the EIA could be strengthened: …
>
> - Further consideration and commitment to monitoring of the overrepresentation of certain groups within and at particular stages within the FtP process
> - More detail on how bias mitigation within the FtP process will be achieved, whether committee training supports this and how consistency of decision-making will be monitored
> - Reference to how the GCC will monitor whether access to representation may affect engagement with fitness to practise proceedings and consider whether further support, guidance or communication materials could assist registrants participating without representation
>
> • **Comment from a regulator**

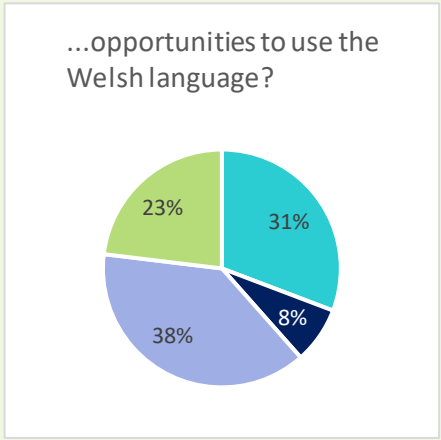
We agree with the importance of committee training, and monitoring of the process for trends (e.g. overrepresentation or access to legal representation), however these are matters for the GCC and not the PCC or HC. These comments will be stored and considered (as appropriate) as the FTP process is continually developed and reviewed.

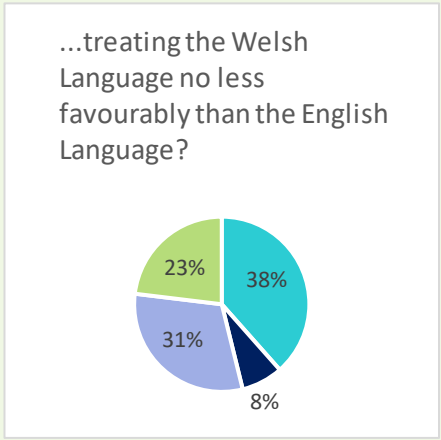
Equality and Welsh language Impact Assessment Questions

Do you think that the Equality and Welsh Language Impact Assessment (E&WLIA) accurately describes how the proposed guidance could impact (positively or negatively) individuals or groups with one or more of the protected characteristics defined in the Equality Act 2010?

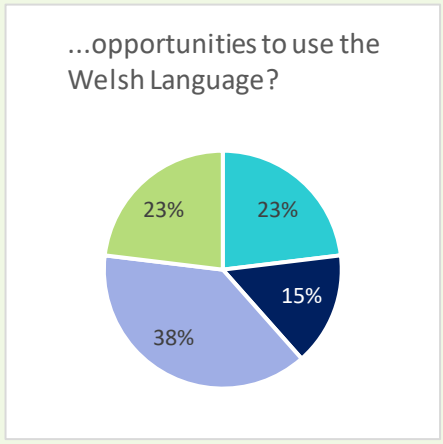


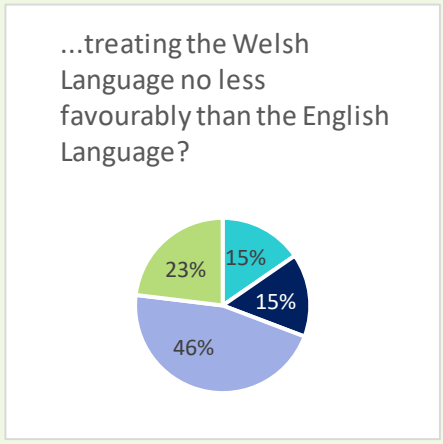
Welsh Language:
Does the E&WLIA accurately describes all the impacts (positive and negative) that the proposed GCC Guidance could have on…



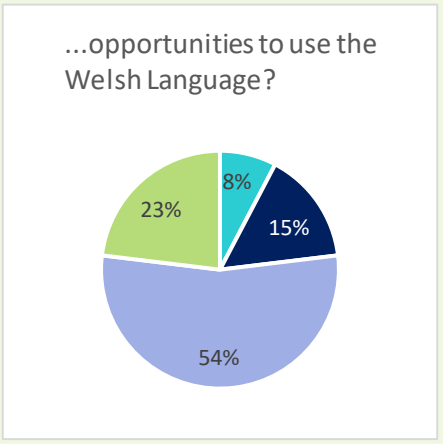


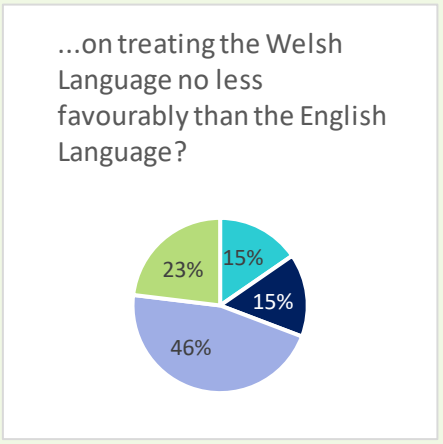
Could the GCC guidance be revised so that it would have a positive impact, or increased positive effects, on…





Could the GCC guidance be revised so that it would not have an adverse impact, or would have decreased adverse impacts, on…





Appendix 1 - Consultation Survey Questions

The following questions were asked of respondents:

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1. Which of the following best describes your interest in chiropractic and reason for responding to the consultation? (Select up to three choices)

    - I am a chiropractor currently registered with the General Chiropractic Council
    - I am qualified as a chiropractor but not currently registered with the General Chiropractic Council
    - I am a patient or member of the public
    - I work or study at an academic institution that carries out chiropractic education or research
    - I work for a chiropractic clinic
    - I am responding on behalf of a membership body, company, organisation or charity
    - I am a qualified healthcare professional (not a chiropractor)
    - Other (please specify):

2. Do you have direct experience of a Fitness to Practise hearing (either held by the GCC or another health professional regulator)? (Please select the most appropriate option)

    - Yes - I have been a witness in a Fitness to Practise hearing
    - Yes - I have been a legal representative in a Fitness to Practise hearing
    - Yes - I have been a panellist or committee member at a Fitness to Practise hearing
    - Yes - I have been a defendant in a Fitness to Practise hearing
    - No. I have not had direct experience of a Fitness to Practise hearing
    - I'd prefer not to say.

3. Which country do you live in?

Areas where we regulate chiropractors

- England
- Northern Ireland
- Scotland
- Wales
- Gibraltar
- Isle of Man

Other

- Prefer not to say
- Other (please specify country):

Only answer these questions if you are a chiropractor currently registered with the General Chiropractic Council

4. Are you currently registered as practising or non-practising?
    - Practising
    - Non-practising
5. How long have you been registered with the GCC?
    - Less than 2 years
    - 2 - 5 years
    - 6 - 10 years
    - 11 - 15 years
    - 16 - 20 years
    - over 20 years

Only answer these questions if you are responding on behalf of an organisation

6. What is your name?
7. What is your email address? (We will only use this if we need to clarify any details in your response).
8. What is the name of the organisation you are responding on behalf of?
9. If you would like to give us further information about your organisation, please do so here:

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10. How much do you agree or disagree with the following statements about the proposed GCC Guidance on Sanctions?

Strongly agree *Agree* *Neither agree nor disagree* *Disagree* *Strongly disagree*

- The guidance supports fair decisions on sanctions.
- The guidance supports consistent decisions across similar cases.
- The guidance supports proportionate decisions on sanctions.
- The guidance clearly explains the factors relevant to deciding the appropriate sanction.
- The guidance helps decision-makers balance public protection, proportionality and fairness.
- The guidance sets out the sanctions decision-making process in a logical order.
- The guidance is easy to understand.

Your views: should we remove or amend anything from the proposed guidance?

11. Are there any key areas that you think should be amended or removed in the proposed GCC Guidance on Sanctions?

- Yes (we will ask you to provide more information in the next question)
- No
- Not sure/no opinion

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12. Please explain any areas that you consider should be amended or removed in the proposed GCC Guidance on Sanctions?

Your views: is there anything missing from the proposed guidance?

13. Are there any key areas that you think are missing from the proposed GCC Guidance on Sanctions?

- Yes (we will ask you to provide more information in the next question)
- No
- Not sure/no opinion

---

14. Please explain any areas that you consider are missing from the proposed GCC Guidance on Sanctions?.

Our commitment to Equality, Diversity and Inclusion

15. Do you think that the Equality and Welsh Language Impact Assessment (E&WLIA) accurately describes how the proposed guidance could impact (positively or negatively) individuals or groups with one or more of the protected characteristics defined in the Equality Act 2010?

- Yes
- No
- Don't know / not sure
- I have not read The Equality Impact Assessment

Please add any further comments or observations on the Equality and Welsh Language Impact Assessment (E&WLIA), or on how the proposed guidance could impact those with one or more protected characteristics.

The Welsh Language Standards

16. The following optional questions are about how the Equality and Welsh Language Impact Assessment (E&WLIA) considers the impact of the proposed GCC Guidance for Decision Makers: Sanctions on the Welsh Language:

Yes *No* *Don't know / not sure* *I have not read the E&WLIA*

Does the Equality and Welsh Language Impact Assessment describe all the impacts of the guidance?

- Does the E&WLIA accurately describes all the impacts (positive and negative) that the proposed GCC guidance could have on **opportunities to use the Welsh language?**
- Does the E&WLIA accurately describes all the impacts (positive and negative) that the proposed GCC guidance could have on **treating the Welsh Language no less favourably than the English Language?**

Could the guidance be revised to increase positive impacts?

- Could the proposed GCC guidance be revised (beyond the changes already described in the E&WLIA) so that it would have a positive impact, or increased positive effects, on **opportunities to use the Welsh Language?**
- Could the proposed GCC guidance be revised (beyond the changes already described in the E&WLIA) so that it would have a positive impact, or increased positive effects, on **treating the Welsh Language no less favourably than the English Language?**

Could the guidance be revised to decrease adverse impacts?

- Could the proposed GCC guidance be revised (beyond the changes already described in the E&WLIA) so that it would not have an adverse impact, or would have decreased adverse impacts, on **opportunities to use the Welsh Language?**
- Could the proposed GCC guidance be revised (beyond the changes already described in the E&WLIA) so that it would not have an adverse impact, or would have decreased adverse impacts, on **treating the Welsh Language no less favourably than the English Language?**

Please add any further comments or observations on the Equality and Welsh Language Impact Assessment, or on how the proposed GCC guidance could impact opportunities to use the Welsh Language, or treat the Welsh Language less favourably than the English language.

Would you be prepared to answer seven further questions to help us monitor the diversity of respondents, and help us ensure that no-one is disadvantaged or receives less favourable treatment through our activities?

- Yes - please answer questions 17 to 23
- No - please answer question 24.

---

17. Age:

- Under 20
- 20-24
- 25-29
- 30-34
- 35-39
- 40-44
- 45-49
- 50-54
- 55-59
- 60-64
- 65-69
- 70 or over
- Prefer not to say

18. Are you:

- Male
- Female
- Prefer not to say

19. Is your gender identity the same as the sex you were assigned at birth?

- Yes
- No
- Prefer not to say

20. How do you describe your sexual orientation?

- Bi
- Gay man
- Gay woman/lesbian
- Heterosexual/straight
- Prefer not to say

21. How do you describe your religion or belief?

- Baha'i
- Buddhist
- Christian
- Hindu
- Jain
- Jewish
- Muslim
- Sikh
- Other and no religion
- No religion/belief
- Prefer not to say

22. Do you have a disability as defined by the Equality Act 2010?

(This means you have a physical or mental impairment that has a substantial and long-term negative effect on your ability to do normal daily activities).

- Yes
- No
- Prefer not to say

23. How do you describe your ethnic origin?

Arab or Arab British
- Arab
- Other Arab

Asian or Asian British
- Bangladeshi
- Chinese
- Indian
- Pakistani
- Other Asian

Black or Black British
- African
- Caribbean
- Other Black

Mixed ethnic origin
- Asian and White
- Black African and White
- Black Caribbean and White
- Other Mixed

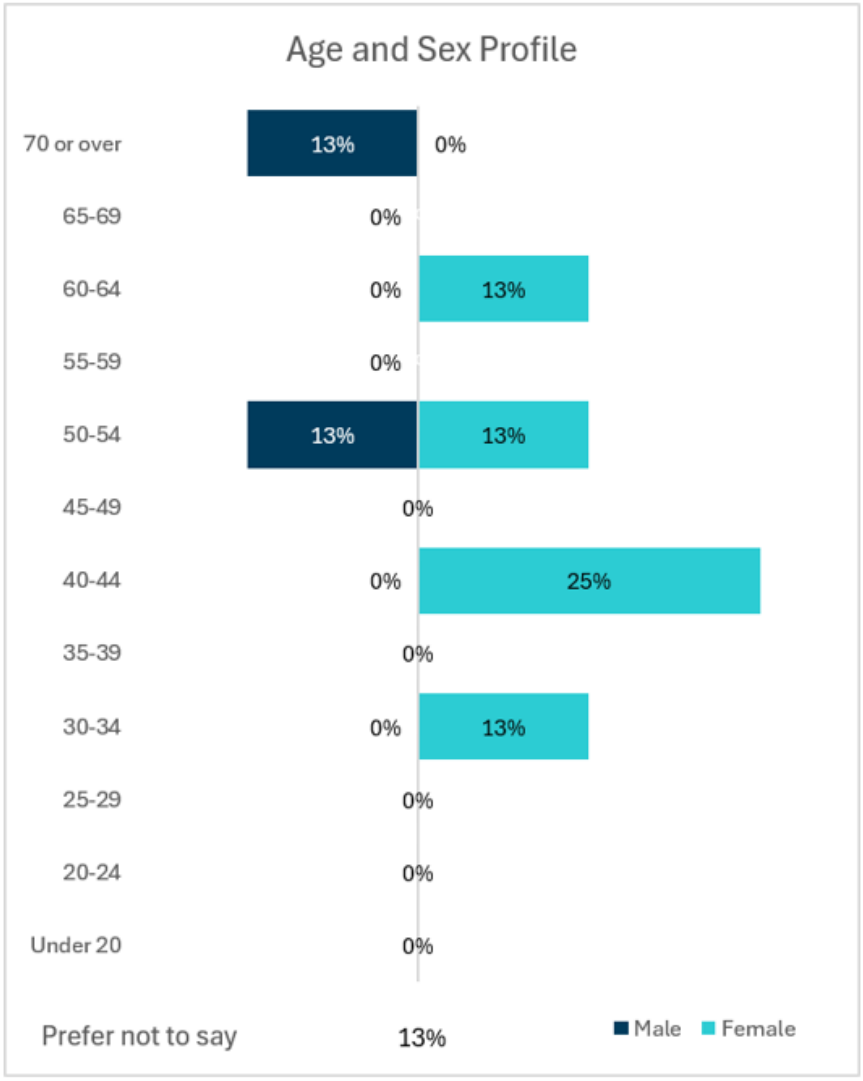
White or White British
- English
- Gypsy/Irish Traveller
- Irish
- Northern Irish
- Scottish
- Welsh
- Other White

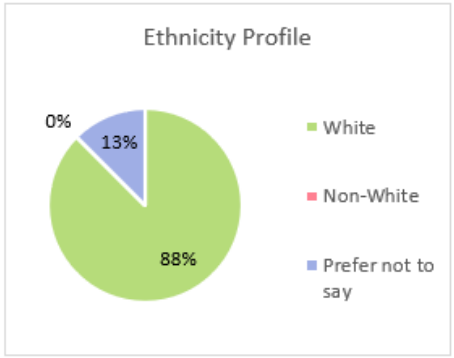
Other
- Prefer not to say
- Other ethnic group (please specify)

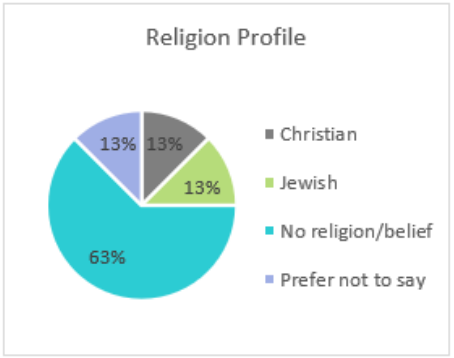
---

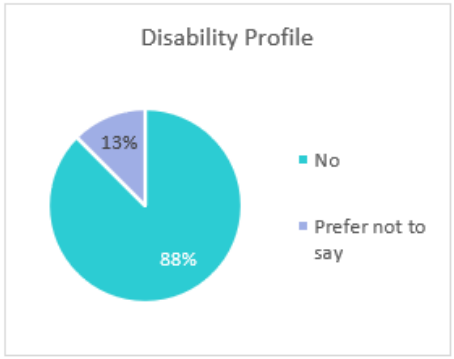
24. Please share any further comments on the proposed GCC guidance or any further comments about this consultation:

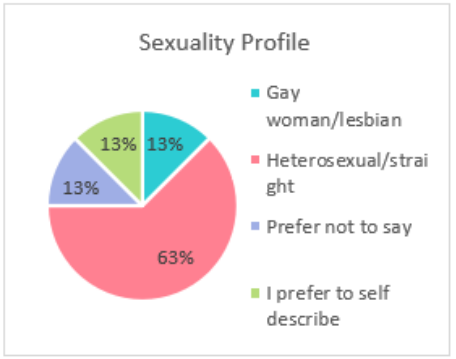
Appendix 2 - Diversity profile of respondents

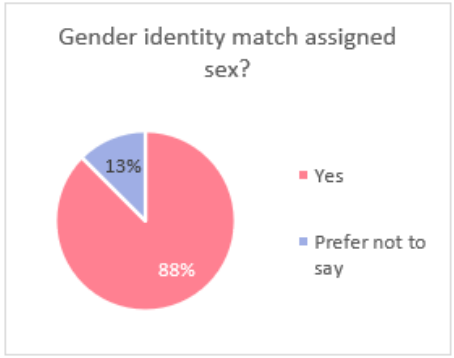












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This document is also available in Welsh.

The General Chiropractic Council Guidance for Decision Makers:

Sanctions

Image: Flaticon.com

GCC Guidance for Decision Makers

The General Chiropractic Council ('the GCC') is the statutory regulator of the chiropractic profession in the UK. Its functions are set out in the Chiropractors Act 1994 ('the Act').[Ref1]

As a regulator we must make difficult decisions that can have a substantial impact on people's lives, and our aspiration is to make these decisions in a more proportionate way. We are seeking fairer, objective and consistent decision-making that recognises and mitigates the risk of bias.

The General Chiropractic Council's Guidance for Decision Makers aims to promote consistency and openness in decision-making. It ensures that all parties are aware from the outset of the approach we will take when making decisions.

The guidance may also be useful for chiropractors and members of the public who wish to understand more about the regulation of the chiropractic profession.

The guidance provides the framework for decisions and how the decision maker is expected to apply it. The guidance is there to assist in making decisions that are transparent, fair and consistent and, whilst it is guidance, the decision maker should provide clear written reasons for any deviation from it.

The Purpose of this Guidance

This guidance has been developed by the GCC for use by the Professional Conduct Committee ('the PCC') and Health Committee ('the HC') when considering what sanction to impose upon a chiropractor. It outlines the decision-making process and the factors to be considered.

The guidance is intended to be considered within the context of the legislation, rules, guidance and policies which govern the approach of the PCC and HC.

Publication History

This edition published 01 November 2026.

Changelog

Date	Change
November 2026	Fully revised and updated with reference to the Code of Professional Practice (2026) [Ref2]. Includes a clearer staged approach to decisions and wider guidance on specific cases (including where discrimination or sexual misconduct are a factor).
May 2018	Third edition published.
August 2010	Second edition published.
Autumn 2004	First edition published.

Contents

The Role and Status of the Guidance on Sanctions

1. The General Chiropractic Council ('the GCC') is the statutory regulator of the chiropractic profession in the UK. Its functions are set out in the Chiropractors Act 1994 ('the Act') Ref1.
2. This guidance has been developed by the GCC for use by the Professional Conduct Committee ('the PCC') and Health Committee ('the HC') when considering what sanction to impose upon a chiropractor. It outlines the decision-making process and the factors to be considered.
3. The sanctions guidance aims to promote consistency and openness in decision-making. It ensures that all parties are aware from the outset of the approach to be taken to sanctions by committees.
4. The guidance may also be useful for chiropractors and members of the public who wish to understand more about the regulation of chiropractors.
5. This guidance provides the framework for sanction decisions and committees are expected to apply it. The guidance is there to assist the committee in making decisions that are transparent, fair and consistent. Whilst it is guidance, the committee should provide clear written reasons for any deviation from it.
6. The guidance on sanctions is an important link between two regulatory roles of the GCC: setting standards of conduct and practice for the profession and dealing with complaints against chiropractors. The Council of the GCC is responsible for all decisions taken by the PCC and the HC, although Council members do not sit on either committee. The chiropractic and lay members appointed by the Council to sit on the PCC and HC must use their own judgement in deciding whether allegations against chiropractors are well-founded. These independent decisions must take account of the requirements of the Code of Professional Practice Ref2, effective 1 January 2026 and any other guidance the GCC issues to the profession.
7. The GCC has a legal duty[1] to meet the Welsh language standards which includes a right to participate in legal proceedings in Welsh. The GCC and committee will provide appropriate support to a chiropractor (or other participants) to assist them to use the Welsh language; and will not draw adverse conclusions from their use of the Welsh language or otherwise treat the Welsh language less favourably than English.
8. This guidance was published on 1st November 2026 and comes into effect from 1 November 2026.

[1] Welsh Language Standards (No.8) Regulations (2022)

Approach to Sanctions and Reasons

9. A purpose of this guidance is to promote consistency in decision-making, though each case will be considered on its own facts. Decision makers should be clear about why a particular sanction has been imposed in each case.

10. Any list of factors referenced in this guidance should be considered as a non-exhaustive list. Committees should use their discretion when imposing sanctions and can consider any other factors they consider necessary and proportionate.

Why are sanctions imposed?

11. The main reason for imposing sanctions is to protect the public, which is the statutory over-arching objective of the GCC.[2]

12. The pursuit of protection of the public involves acting[3]:

> a) to protect, promote and maintain the health, safety and well-being of the public;
> b) to promote and maintain public confidence in the profession of chiropractic; and
> c) to promote and maintain proper professional standards and conduct for members of the chiropractic profession.

13. The purpose of a sanction is not to punish, though a sanction may have a punitive or negative impact upon a chiropractor. The impact of the sanction on the individual chiropractor this will not usually affect the committee's assessment of what is the minimum sanction necessary to protect the public, maintain confidence and uphold standards.

The nature of allegations

14. The Act sets out four types of allegation[4]:

> a) the chiropractor has been guilty of conduct which falls short of the standard required of a registered chiropractor. This is further defined in the Act[5] as "unacceptable professional conduct", referred to in this guidance as ”UPC”;
> b) the chiropractor has been guilty of professional incompetence;
> c) the chiropractor has been convicted (at any time) in the United Kingdom of a criminal offence;
> d) the chiropractor's ability to practise as a chiropractor is seriously impaired because of their physical or mental condition.

15. Where such an allegation is made the GCC will refer it for consideration by the Investigating Committee ('the IC'). If the IC considers there is a case to answer, allegations concerning a chiropractor's physical or mental health will be referred to the HC and allegations of any other kind will be referred to the PCC[6].

[2] Chiropractors Act (1994) Section 1(4A) Ref1
[3] Chiropractors Act (1994) Section 1(4B) Ref1
[4] Chiropractors Act (1994) Section 20(1) Ref1
[5] Chiropractors Act (1994) Section 20(2) Ref1
[6] Chiropractors Act (1994) Section 20(12) Ref1

The staged approach

16. Committees must follow a sequential approach before moving to consider sanction. The approach to be followed depends on the type of allegation.

Allegations of unacceptable professional conduct, or professional incompetence

17. In the case of an allegation concerning either UPC or professional incompetence, the PCC must decide in this order:

> a) whether the facts as set out in the allegation have been proved by the GCC according to the "balance of probabilities". This means the GCC must prove that it is more likely than not that whatever is alleged occurred. It is not for the chiropractor to disprove the allegation. If none of the facts have been proved, the allegation is not well-founded;
> b) whether, if any of the facts have been found to be proved, some or all of these (whether taken individually or collectively) constitute UPC or professional incompetence, as alleged. If the PCC finds they do not, the allegation is not well-founded;
> c) if the threshold for UPC or professional incompetence is met, which of the sanctions available is the minimum necessary to protect the public.

18. The PCC will approach its decision by making determinations on each of these three stages.

19. The standards required of a registered chiropractor are set out in the Code of Professional Practice[Ref2]. The Act provides that, where a chiropractor is alleged and found to have breached any provision within the Code of Professional Practice, this shall not be taken, of itself, to constitute UPC but will be taken into account[7]. This is also the approach to be taken in cases of alleged incompetence.

Allegations of conviction in the United Kingdom of a criminal offence

20. In the case of an allegation concerning a conviction, the PCC must decide in this order:

> a) whether the fact of the conviction is proven. If the fact of the conviction is not proven, the allegation is not well-founded. If the fact of the conviction is proven, the matter is well-founded;
> b) if the allegation is well-founded, whether the criminal offence has any material relevance to the fitness of the chiropractor to practise chiropractic. If it has no material relevance, the PCC may take no further action;
> c) if the criminal offence has material relevance, which of the sanctions available is the minimum necessary to protect the public.

21. The PCC will approach its decision by making determinations on each of these three stages. The definition of a conviction and the process to be followed by the PCC in such cases is set out in more detail below.

[7] Chiropractors Act (1994) Section 19(4) [Ref1]

Allegations of serious impairment due to the chiropractor's physical or mental condition.

22. In the case of an allegation concerning impairment of an ability to practise due to a physical or mental condition, the HC has to decide in this order:

a) whether the GCC has proved, on the balance of probabilities, that the chiropractor suffers from the physical or mental condition as alleged. If the HC finds that is not proved, the allegation is not well-founded;
b) whether, if the GCC has proved that the chiropractor suffers from the physical or mental condition as alleged, the chiropractor's ability to practise as a chiropractor is seriously impaired as a result of the proven physical or mental condition. If the HC finds that it is not, the allegation is not well-founded;
c) if threshold for impairment based on a physical or mental condition is met, which of the sanctions is the minimum necessary to protect the public.

23. The HC will approach its decision by making determinations on each of these three stages.

Allegations that are not well founded

24. Where a committee finds that an allegation is not well-founded, no action is taken and the chiropractor is informed of this outcome. The committee must give full reasons for the decision in its written determination.

Allegations that are well founded

25. Where a committee finds that an allegation is well founded (and in the case of conviction also materially relevant), then the committee must impose a sanction (there is no option not to apply a sanction).[8],[9]

Sanction Submissions

26. Where the allegation is well founded, both the GCC and the chiropractor may make submissions about the appropriate sanction to impose. The committee should take account of those submissions when deciding the appropriate sanction but is not bound by them.

[8] Chiropractors Act (1994) Section 22(4) Ref1
[9] Chiropractors Act (1994) Section 23(2) Ref1

The approach to sanction

27. The committee will take the following approach to sanction:

a) remind itself of its factual findings and reasons for finding any allegation well-founded and ensure that its decision on sanction is not inconsistent with those earlier findings;
b) consider the available sanctions in ascending order, starting with the least restrictive option, moving upwards if that option is thought to be insufficient, and stopping when it reaches the least restrictive sanction necessary to protect the public.
c) The committee will need to explain why the next most restrictive sanction is not considered necessary;
d) consider any other factors and evidence relevant to sanction;
e) identify any mitigating and aggravating factors;
f) have regard to whether the conduct falls within the particular categories of case identified by this guidance;
g) consider whether to order a Review Hearing;
h) where a sanction of Suspension Order or Removal Order is made, consider whether an Interim Suspension Order is necessary.

28. The committee must always keep the statutory over-arching objective to protect the public, and the three limbs set out in paragraph 11, in the forefront of its mind.

Reasons

29. The committee's written determination must provide clear and cogent reasons for imposing a particular sanction, including explaining the relevance of any mitigating and aggravating factors.

30. Committees will ensure reasoning on sanction is consistent with its findings on the allegations.

31. If the sanction imposed is lower or higher than that suggested by this guidance, the reasons for that will be explained in the written determination.

32. If the committee orders a sanction that will remain in place for a fixed period, the written determination will also include a clear explanation of why a particular period has been considered necessary.

33. The written determination must set out whether the committee considered imposing a more restrictive sanction and provide reasons for any conclusion that a more restrictive sanction was unnecessary.

34. The reasons must summarise the committee's findings on the principal important issues in the case, to enable the chiropractor and the public to understand:

a) why a particular sanction has been chosen;
b) how it protects the public;
c) why it is the minimum sanction that is necessary.

The Available Sanctions

35. There are four sanctions available to the PCC:

    a) Admonishment;
    b) Conditions of Practice Order (of up to three years);
    c) Suspension Order (of up to three years);
    d) Removal from the register.

36. There are two sanctions available to the HC:

    a) Conditions of Practice Order (of up to three years);
    b) Suspension Order (of up to three years).

37. Each of these sanctions is addressed individually below.

38. The chiropractor has the right to appeal to the courts within 28 days against any decision of the PCC or HC. The sanction does not take effect during these 28 days nor, if an appeal is lodged, until that appeal has been disposed of. During this time, the chiropractor's registration remains fully effective unless the committee also orders an Interim Suspension.

Admonishment

39. The least restrictive sanction that can be applied by the PCC[10] is an admonishment, which does not directly restrict a chiropractor's ability to practise. An admonishment is only appropriate if the committee has decided there is no risk to the public requiring the chiropractor's practice to be restricted.

40. An admonishment may be appropriate if:

    a) the allegation of unacceptable professional conduct, professional incompetence or criminal conviction is at the lower end of the spectrum of seriousness; and
    b) the PCC wants to mark that the behaviour of the chiropractor was unacceptable and must not happen again.

41. Admonishments may be considered when most of the following factors are present:

    a) the behaviour did not and could not have caused direct or indirect patient harm;
    b) the chiropractor has sufficient insight into the matters found proved;
    c) the behaviour was an isolated incident, which was not deliberate;
    d) a genuine expression of regret or apology;
    e) an absence of previous regulatory findings;
    f) no repetition of the behaviour since the incident;
    g) evidence that effective rehabilitative or corrective steps have been taken.

42. The PCC will explain why an admonishment is considered proportionate, and a more serious sanction is not considered necessary, having regard to any of the factors listed above that are relevant.

[10] Chiropractors Act (1994) Section 22(4a) Ref1

43. An admonishment will be based upon the findings made by the PCC, explaining why the conduct should not be repeated by reference to the Code of Professional Practice.

44. An admonishment will be published against the registrant's entry in the register for the period of time specified in the GCC Publication and Disclosure Policy Ref3.

Escalation

45. If the PCC concludes that imposing an admonishment will not be sufficient in the circumstances of the case, having regard to the over-arching objective, it must go on to consider imposing a Conditions of Practice Order on the chiropractor's registration.

Conditions of Practice Order (PCC)

46. A Conditions of Practice Order requires the chiropractor to comply with certain conditions before they are permitted to resume unrestricted registration. Such an order can be imposed by the PCC for a period of up to three years in the first instance and may be extended or further extended for periods of up to three years subsequently at review hearings.

47. The main aim of specific conditions is to protect patients from harm, while allowing the chiropractor to put right any shortcomings in their practice which led to a finding of UPC or professional incompetence or to manage any health issues (depending on the nature of the allegation).

48. Where imposed by the PCC, a Conditions of Practice Order must specify one or both of the following:

> a) the period for which the order is to have effect;
> b) a test of competence which must be taken by the chiropractor.[11]

49. Where imposed by the PCC, a Conditions of Practice Order will end:

> a) if a period is specified in the Order, when that period ends;
> b) if no period is specified but a test of competence is specified, when the chiropractor passes the test; or
> c) if both a period and a test are specified, whichever is the later of the period ending or the chiropractor passing the test.[12]

50. The objectives of any conditions within a Conditions of Practice Order must be made clear enough for:

> a) the chiropractor to know what is expected of them; and
> b) the committee at any future review hearing to be able to understand the chiropractor's original shortcomings and the specific actions needed to correct them.

[11] Chiropractors Act (1994) Section 22(5) Ref1
[12] Chiropractors Act (1994) Section 22(6) Ref1

51. Only when the objectives are set out clearly will it be possible to evaluate whether they have been achieved. Any conditions must be:

a) specific;
b) relevant and appropriate;
c) proportionate;
d) workable;
e) measurable.

52. Committees should consider the GCC Bank of Conditions Ref4 when deciding which conditions to impose in a case. The conditions bank is indicative, and the committee is not limited to these conditions.

53. Before the committee decides on any conditions to be imposed, it will consider inviting any submissions from the GCC and the chiropractor as to whether the proposed conditions will be workable. This is likely to be particularly important if the committee intends to impose conditions requiring workplace supervision. Seeking such submissions may mean the committee needs to adjourn for a brief period of time to allow the GCC and chiropractor an opportunity for consideration.

54. Committees must take care to ensure that the conditions imposed are not so restrictive as to be tantamount to a Suspension Order. In circumstances where a committee is unable to formulate workable conditions that sufficiently protect the public, it is likely to be appropriate instead to consider a Suspension Order.

55. A Conditions of Practice Order may be appropriate when most or all of the following are present:

a) there is no evidence of harmful deep-seated personality or attitudinal problems;
b) there are identifiable areas of a chiropractor's practice in need of review, retraining or assessment;
c) there is evidence of a willingness to undertake, and the potential to respond positively to, further training and assessment (where the allegation does not relate solely to ill-health);
d) the chiropractor has insight into any health problems seriously impairing their ability to practise and is prepared to agree to abide by conditions relating to medical condition, treatment and supervision;
e) patients will not be put at risk either directly or indirectly as a result of continued registration with conditions;
f) the conditions will protect patients during the period they are in force;
g) it is possible to formulate appropriate, practicable and assessable conditions to impose on registration.

56. Committees will need to give careful consideration to the length of a Conditions of Practice Order and provide reasons for the length of the order. In determining the length, the committee should be satisfied the order's duration is proportionate and may consider:

a) the degree of risk to public protection posed by the chiropractor;
b) the degree of risk to public confidence in the chiropractic profession;
c) the amount of time which is likely to be needed to undertake any training for the purpose of demonstrating remediation;
d) the committee's reasons for assessing conditions as being the proportionate response to its findings.

57. Details of a Conditions of Practice Order will be published against the registrant's entry in the register for the period of time specified in the GCC Publication and Disclosure Policy Ref3.

Escalation

58. If the PCC concludes that imposing a Conditions of Practice Order will not be sufficient in the circumstances of the case, having regard to the over-arching objective, it must go on to consider imposing a Suspension Order on the chiropractor's registration.

Ordering a Review Hearing when imposing a Conditions of Practice Order:

59. When imposing a Conditions of Practice Order, the committee should consider if they wish for it to be reviewed prior to its expiry. The committee can order a Review Hearing to consider whether the chiropractor is fit to resume practice before the Order expires.

60. When ordering a review, the committee should be clear as to the purpose of the order and the evidence that would likely assist the reviewing committee to assess compliance with the conditions.

61. If the committee does not consider that a Review Hearing is necessary, it should clearly explain its reasons in its determination.

62. There are more details about Review Hearings and the options available to the committee when reviewing a sanction when reviewing a sanction at paragraphs 197 – 219 of this guidance.

Suspension Order (PCC)

64. A Suspension Order directs the Registrar to suspend the chiropractor's registration for a period of up to three years. This means the chiropractor cannot practise as a registered chiropractor whilst the Suspension Order is in place.

65. Suspension is likely to be appropriate for UPC, professional incompetence or a conviction that is serious, but not so serious as to justify removal from the register. Suspension can be used to send out a signal to the chiropractor, the profession and the public about what is regarded as a serious departure from the standards expected of a registered chiropractor.

66. Suspension may be appropriate in a case where the chiropractor poses a risk of harm to patients, but where there is evidence that they have gained insight into the deficiencies and there is potential and willingness for them to remedy their shortcomings. This will include cases where a Conditions of Practice Order is not sufficient either to protect patients directly or to meet the other elements of the over-arching objective that relate to maintaining public confidence in the profession and upholding professional standards. In such cases, the committee may wish to impose a period of suspension and to make recommendations as to the evidence which the chiropractor may wish to bring to any future review hearing; for example, evidence of further training.

67. Suspension Orders may be appropriate when some or all of the following are present:

a) there has been a serious breach of the Code of Professional Practice and, while the UPC or conviction concerned is not fundamentally incompatible with continued registration, the breach is so serious that any sanction lower than a suspension would not be sufficient to meet the over-arching objective;
b) the case involves professional incompetence where there is a risk to patient safety if the chiropractor's registration is not suspended;
c) the chiropractor demonstrates potential and willingness to remediate their deficiencies and failings;
d) there is no evidence of harmful deep-seated personality or attitudinal problems;
e) there is no evidence of repetition of similar behaviour since the incident;
f) the committee is satisfied the chiropractor has insight and does not pose a significant risk of repeating the behaviour.

Duration of a suspension order

68. Committees will need to give careful consideration to the length of a Suspension Order and provide reasons for the length of the order. In determining the length, the committee should be satisfied the order's duration is proportionate and may consider:

a) the degree of risk to public protection posed by the chiropractor;
b) the degree of risk to public confidence in the chiropractic profession;
c) the amount of time which is likely to be needed to undertake any training for the purpose of demonstrating remediation;
d) whether to account for any previous interim suspension orders;
e) the committee's reasons for assessing conditions as being the proportionate response to its findings.

69. Whilst the committee has the power to impose a suspension of up to three years, it must impose the minimum required for protection of the public, taking into account the statutory over-arching objective to protect the public, and the three limbs set out in paragraph 11, in the circumstances of the particular case.

70. Where a committee considers remediation is unlikely to be achieved within 12 months it should consider carefully whether its findings are compatible with continued registration.

Further considerations

71. Suspension from the register will have a punitive effect, in that during the period of the order it prevents a chiropractor from practising as a registered chiropractor. However, if the committee determines that a suspension is the proportionate sanction to fulfil the statutory over-arching objective, including maintaining public confidence in the profession, then it must impose that sanction.

72. Details of a Suspension Order will be published against the registrant's entry in the register for the period of time specified in the GCC Publication and Disclosure Policy Ref3.

Escalation

73. If the PCC concludes that imposing a Suspension Order will not be sufficient in the circumstances of the case, having regard to the over-arching objective, it must go on to consider removal of the chiropractor's name from the register.

Ordering a Review Hearing when imposing a Suspension Order

74. When imposing a Suspension Order, the committee should consider if they wish for it to be reviewed prior to its expiry. The committee can order a Review Hearing to consider whether the chiropractor is fit to resume practice before the Order expires.

75. When ordering a review, the committee should be clear as to the purpose of the order and the evidence that would likely assist the reviewing committee to assess insight and remediation.

76. In some cases – for example those where there is well-developed insight, remorse, proper remediation, no risk to the public and no risk of repetition – it may be self-evident that, following a period of suspension, there would be no necessity to review the order.

77. If the committee does not consider that a review hearing is necessary, it should clearly explain its reasons in its determination.

78. There are more details about Review Hearings and the options available to the committee when reviewing a sanction when reviewing a sanction at paragraphs 197 – 219 of this guidance.

Protecting the public before a Suspension Order comes into effect

79. In cases when the PCC decides to impose a Suspension Order, the committee will consider whether it is necessary to impose an Interim Suspension Order to protect members of the public during the period until the Suspension Order comes into effect[13].

80. A Suspension Order does not take effect for 28 days and, if an appeal is lodged, not until the appeal has been decided, during which time the chiropractor would remain on the register and be able to practise, if an Interim Suspension Order has not also been imposed.

81. Further detail on Interim Suspension Orders is contained below.

[13] Chiropractors Act (1994) Section 24(2) Ref1

Removal from the register

82. This sanction requires the Registrar to remove the chiropractor's name from the register, thus prohibiting that individual from working as a chiropractor in the UK. Removal from the register may be necessary when the conduct involves any of the following:

a) a particularly serious departure from the principles set out in the Code of Professional Practice where the conduct is considered to be fundamentally incompatible with being a chiropractor;
b) their ability to practise safely and effectively is incompatible with continued registration at this point in time. It means the level of current and ongoing risk the chiropractor poses to public protection is so significant that they should not be allowed to practise;
c) a reckless disregard for the principles set out in the Code of Professional Practice and for patient safety;
d) doing serious harm to others (patients or otherwise), either deliberately or through incompetence; particularly where there is a continuing risk to patients (see Failing to Provide an Acceptable Level of Treatment or Care);
e) abuse of position of trust;
f) violation of a patient's rights or exploiting vulnerable people;
g) sexual misconduct, including involvement in child sexual exploitation;
h) offences involving serious violence that have resulted in a custodial sentence;
i) dishonesty, especially when it is denied, persistent or covered up;
j) acting without integrity;
k) abusing professional standing;
l) persistent lack of insight into the seriousness or consequences of their actions;
m) discrimination, harassment or victimisation based on a protected characteristic.

83. Details of a Removal Order will be published against the registrant's entry in the register for the period of time specified in the GCC's Publication and Disclosure Policy [Ref3].

Protecting the public before a Removal Order comes into effect

84. In cases where the PCC decides to remove a chiropractor from the register, it will consider whether it is necessary to impose an Interim Suspension Order to protect members of the public during the period before the removal takes effect.

85. A Removal Order does not take effect for 28 days and, if an appeal is made, not until the appeal has been decided, during which time the chiropractor would remain on the register and be able to practise.

86. Further detail on Interim Suspension Orders is contained below.

Factors and Evidence

87. Committees will need to consider a range of factors when making a decision about what sanction to impose. Crucial to that decision will be the findings made by the committee and it must ensure its decision on sanction is consistent with those. This section of the guidance outlines some of the factors and evidence which a committee will commonly need to consider.

Harm caused or risk of harm

88. Harm may take many forms, for example, it can be physical, psychological, emotional or financial. Complainants may not always wish to provide evidence about the impact of the conduct upon them (or the person being harmed or at risk of harm). However, where evidence of impact is available from the complainant a committee may take that evidence into account in assessing seriousness.

89. One of the key considerations is the extent of harm or risk of harm caused to the public. That may be evidenced by the degree of harm caused by the chiropractor's conduct. However, the risk of harm caused by their conduct may be just as important as the degree of any actual harm caused. This is because acting in the same way again could result in actual harm.

90. In some cases, it will be relevant for a committee to consider the extent to which the harm or conduct was deliberate and/or reckless.

91. In some cases, it will be relevant for a committee to consider the extent to which the chiropractor could, and should, have foreseen the degree of risk.

Repetition

92. Committees should consider the extent to which there is a risk of the conduct being repeated.

93. A risk of repetition is likely to increase the seriousness of the case as it will typically mean there is a greater risk of harm being caused.

94. Where the committee has found conduct representing a departure from the standards expected to have occurred on multiple occasions, rather than the conduct being an isolated incident, it may conclude there is an increased risk of future repetition.

Assessing insight and remediation

95. Insight and remediation are closely linked to repetition. However, there will be some cases where the conduct has such a significant impact on public confidence in the profession that even if the chiropractor has demonstrated insight and sought to remediate, a serious sanction is nevertheless required.

96. Insight and remediation may be evidenced through written reflections, oral evidence, or a combination of both. Committees should focus on the substance, quality and authenticity of the statement rather than the method by which it is presented, or the existence of a reflective statement alone.

97. Written evidence may assist a chiropractor to provide a considered and structured account of their understanding of the concerns, the impact of their conduct and the steps taken to address any shortcomings. However, committees should recognise that written material alone may not always provide a complete basis on which to assess the depth, authenticity or sustainability of insight or remediation, particularly where the issues are serious or complex, or the chiropractor has received significant assistance in preparing their statement.

98. Oral evidence may assist a committee in exploring and testing a chiropractor's understanding of the concerns, their reflections on the impact of their conduct and the credibility of the steps they have taken to remediate. However, committees should recognise that the ability to communicate insight orally may be influenced by factors such as culture, language, gender, disability, health conditions, stress or anxiety associated with the proceedings.

99. Committees should evaluate all available evidence in the round and should not attach disproportionate weight to either written or oral evidence. The weight given to any evidence will depend on the circumstances of the case and the extent to which it assists the committee in assessing the chiropractor's insight and remediation.

100. Committees should be aware that different practitioners may express insight or remorse in different ways. Cross-cultural communication studies show that there are significant differences in the way that people from different cultures, genders and language groups use language and non-verbal signals both to understand what is being said and to express themselves. This is particularly the case when individuals are using a second language. Committees should also have regard to any independent expert evidence presented by a practitioner that establishes that they have a particular health condition that impacts on the way in which they express remorse. Awareness of and sensitivity to these issues are important in considering and assessing the degree of insight or remorse shown.

101. Committees will be mindful that the absence of evidence does not necessarily demonstrate lack of insight and a chiropractor (particularly where they are not represented) should be invited to provide evidence before an assessment is made.

Considering apologies

102. Apologies are an important aspect of an individual’s duty of candour. The Code of Professional Practice and Guidance for Registrants: Duty of Candour expects registrants to apologise to a patient or their carer when something has gone wrong with the care, treatment or other services that they provide. An apology may be one of the ways an individual demonstrates insight.

103. The timing and nature of any apology will be informed by context and the working environment of the chiropractor. While a timely apology is encouraged, there may be good reason for a delay in any apology being offered, and panels should consider the various reasons why an apology may not be given. For example, chiropractors, including those who have limited access to legal advice, may fear the impact an apology will have on liability. Different cultural factors, neurodiversity, and lived experience may also impact on whether a chiropractor apologises, or how they frame an apology or insight.

104. For the purposes of fitness to practise proceedings before a committee, of itself an apology will not be treated as an admission of the facts alleged or of current impairment.

Insight

105. Committees will consider evidence of insight and assess the degree of insight. This will involve considering what has happened since the conduct occurred and the chiropractor's response to the concerns.

106. Insight may be present when a chiropractor can demonstrate they understand why the conduct arose and the steps needed to prevent the same thing occurring again.

107. Where insight is a significant factor to the decision on sanction, and particularly where the case involves serious misconduct, attitudinal issues, discrimination, exploitation, dishonesty or abuse of trust, a committee may conclude that written reflections alone are insufficient and may require oral evidence from the chiropractor, or further independent corroborating evidence, before determining the extent of insight demonstrated.

108. In health cases, insight may be demonstrated by seeking appropriate support for a condition and voluntarily putting in place any necessary steps to protect patients.

109. Committees will have regard to when insight developed. Where concerns are accepted at an early stage, or even where insight can be demonstrated prior to referral of the concerns to the GCC, a committee may place more weight than where insight arises after adverse findings have been made. Committees should also have regard to the tension inherent in defending against an allegation and then demonstrating insight.

110. Insight may also be a matter of degree. A chiropractor may have more insight, but it may not be complete.

111. A committee may conclude that a chiropractor lacks insight or insight is not genuinely held where:

a) conduct has been repeated;
b) the seriousness or significance of the conduct has been minimised, or others are blamed for the conduct;
c) they failed to cooperate with the investigation by the GCC into the concerns.

112. Committees will consider any expressions of remorse by the chiropractor. However, they will be mindful that an expression of remorse or an apology does not necessarily demonstrate insight.

Remediation

113. Remediation will not generally be possible unless a chiropractor has insight; unless they understand how the concerns arose it will be difficult for them to address the cause of the concerns.

114. Committees will consider whether the conduct is capable of remediation and, if so, whether it has been remedied. If the conduct has been remedied the committee may conclude there is a lower risk of repetition. Examples of activities which may demonstrate a reduction in future risk may include:

a) reflective learning;
b) demonstration of sustained behavioural change;
c) participation in training or development programmes;
d) mentoring or supervision.

115. In cases of professional incompetence, remediation may be demonstrated by successful completion of learning or training which relates to the concerns.

116. Evidence of remediation which is independent is likely to carry more weight than personal statements. Independent evidence may include:

a) certificates from training courses;
b) reports from another chiropractor;
c) medical reports.

Previous regulatory concerns

117. A committee may take account of previous regulatory concerns where it considers them to be relevant.

118. Previous regulatory concerns may take the form of:

a) a finding of facts, impairment or UPC by a PCC or HC;
b) a finding of facts, impairment or UPC by another regulator;
c) a conviction by a court in the UK or elsewhere;
d) receipt of a caution or other evidence of a criminal offence.

119. Previous regulatory concerns are likely to be considered relevant where the chiropractor has engaged in similar conduct to that being considered by the committee. Such concerns may indicate an increased risk of repetition, lack of insight or inability to learn from previous failings. A previous finding of facts that did not cross the threshold of UPC or impairment may be relevant if the current case is considered to be a more serious repetition of previous conduct.

120. Where the conduct being considered by the committee has occurred when the chiropractor was subject to another sanction, for example being convicted of a criminal offence whilst subject to a Conditions of Practice Order following a finding of UPC, this is likely to be regarded as serious.

References and testimonials

121. Positive testimonial evidence concerning the chiropractor's lack of propensity to commit the acts alleged may have been presented at the fact-finding stage of the hearing. At the stage when the committee considers sanction, personal mitigation testimonials may also be presented, for example concerning the chiropractor's standing in the community or the profession. The committee should consider the weight to attach to these.

122. The committee should consider:

a) who the author of any reference or testimonial is and the nature of their relationship with the chiropractor (for example, if they are a current or former employer), the nature and extent of their experience of the chiropractor;
b) when the reference or testimonial was written;
c) how it was solicited;
d) whether the author was aware of the proceedings and the allegations;
e) whether the reference or testimonial appears to be authentic (for example, whether it is signed); and
f) whether the reference or testimonial is relevant to the specific findings made by the committee against the chiropractor.

123. A committee may wish to give more weight to a reference or testimonial if it confirms that the author is willing to attend the proceedings to answer questions. Little weight should be given to a testimonial where it is not clear that the author is aware of the GCC proceedings.

124. The quantity, quality and spread of references and testimonials will vary from case to case and this will not necessarily depend upon the standing of the chiropractor. Committees should keep in mind that there may be cultural or other reasons why a chiropractor does not want to seek testimonials. For example, sharing information about an investigation with family members or colleagues may impact on their private lives in respect of their reputation with their family and community. A committee should not draw adverse conclusions if no references or testimonials are presented.

Proceedings where a chiropractor is unrepresented

125. There are many reasons why a chiropractor may not have legal representation and a committee should not draw adverse conclusions from the fact that they are not legally represented.

126. An unrepresented chiropractor may be apprehensive or nervous about having to present a case before a committee and this may manifest itself in apparently difficult or defensive behaviour. A committee should take steps to ensure that the chiropractor understands the purpose and structure of the sanctions stage, and the evidence and the submissions that will assist the committee.

127. This procedural assistance must not extend to legal advice or advancing a case, but should facilitate effective participation. The committee's written determination should contain a record of the assistance given.

Considering previous interim suspension orders

128. The chiropractor may have been made subject to an interim suspension order suspending their registration during the investigation by the GCC (before the PCC or the HC has reached a relevant decision on any allegation). These orders are imposed by the IC[14] or PCC[15] to protect members of the public and are revoked either when they expire or at the sanction stage of the substantive hearing.

129. There is no principle that (as in criminal proceedings if an individual is remanded in custody) time spent suspended under an Interim Suspension Order must be deducted from the length of any sanction then imposed by the PCC or the HC at a hearing. However, the committee should take account of the interim order and its effect on the chiropractor when deciding whether a sanction is proportionate[16].

130. Where a committee is imposing a sanction of suspension to mark the seriousness of the conduct to maintain public confidence in the profession, but there are no current public protection concerns, it may be appropriate to take into account the duration of a previous Interim Suspension Order[17]. In contrast, if there are ongoing public protection concerns and a period of suspension is considered necessary to allow the practitioner time to remediate then the duration of a previous Interim Suspension Order is less likely to be relevant in determining the choice or duration of the sanction.

[14] Chiropractors Act (1994) Section 21 Ref1
[15] Chiropractors Act (1994) Section 24(2a) Ref1
[16] Akhtar v General Dental Council [2017] EWHC 1986 (Admin)
[17] Kamberova v Nursing and Midwifery Council [2016] EWHC 2955 (Admin)

Mitigating and Aggravating Factors

Mitigating factors

131. When deciding on a sanction, the committee will need to consider any evidence presented by way of mitigation by the chiropractor, or which it identifies as being relevant mitigation.

132. The weight, if any, to be placed on any particular mitigation is a matter for the committee's judgement. It must have the over-arching objective to protect the public in the forefront of its mind when considering the relevance of any mitigation and the weight, if any, to attach to it.

133. There are some cases where, regardless of the mitigation presented, a chiropractor's failings are so serious or persistent that a particular sanction is needed to uphold standards and maintain public confidence.

134. Committees will be mindful that, because they are not concerned with matters of punishment, considerations which would normally weigh in mitigation of punishment in a criminal court are likely to have less relevance in regulatory proceedings.

135. Mitigation should only include factors that genuinely reduce culpability or the seriousness of the conduct.

136. The following are examples of mitigating factors:

a) evidence of the extent of the chiropractor's understanding of and insight into the problem and their attempts to address and remediate it;
b) evidence of remediation;
c) evidence of the chiropractor's overall compliance with important principles of good practice (for example, keeping up to date and working within their area of practice) and overall competence;
d) personal mitigation, including:
    - periods of illness;
    - personal and financial hardship;
    - an absence of previous regulatory findings.
e) where relevant to the concerns, contextual factors such as:
    - the chiropractor's level of experience at the time;
    - any evidence of wider systemic issues in the workplace.

137. In some cases, the stage of the chiropractor's career may be a mitigating factor; for example, because the chiropractor was very inexperienced at the time of relevant events but has subsequently been able to reflect on how they might have done things differently, with the benefit of experience. In other cases, for example those involving predatory behaviour or serious dishonesty, the stage of the chiropractor's career is unlikely to be regarded as mitigation.

138. While systemic factors (for example inadequate supervision, staffing pressures, organisational failures, ineffective governance arrangements, poor workplace culture or deficient training arrangements) will not excuse unacceptable conduct, they may assist committees in understanding how concerns arose and in assessing risk of repetition, remediation and proportionality. Committees may wish to consider to what extent the chiropractor had responsibility and ability to influence systemic issues, and any evidence of their reporting, escalating or acting to reduce the impact of the systemic issues.

139. Committees will be mindful that the absence of what would otherwise be an aggravating factor is not to be treated as a mitigating factor.[18]

Aggravating factors

140. When deciding on a sanction, the committee will need to consider any aggravating factors presented to it, or which it identifies as being relevant.

141. The weight, if any, to be placed on any aggravating factor is a matter for the committee's judgement. It must have the over-arching objective to protect the public in the forefront of its mind when considering the relevance of any aggravation and the weight, if any, to attach to it.

142. Aggravating factors may include:

a) previous regulatory findings;
b) abuse of position of trust;
c) lack of insight;
d) direct or indirect patient harm (or conduct which could foreseeably cause harm);
e) a pattern of UPC over time;
f) discrimination based on a protected characteristic;
g) abuse of vulnerability;
h) deliberate or reckless acts;
i) safeguarding concerns.

[18] Professional Standards Authority v (1) Nursing and Midwifery Council; (2) Judge [2017] EWHC 817 (Admin)

Particular Categories of Case

143. There are some categories of case in which particular considerations arise or in which more serious action is likely to be required. This section of the guidance addresses those:

- Convictions
- Sexual misconduct
- Dishonesty or lack of integrity
- Failing to provide an acceptable level of treatment or care
- Discrimination and harassment,
- Exploitation of vulnerability and victimisation

Convictions

Meaning of 'conviction' and approach to other criminal disposals

144. A 'conviction' within section 20(1)(c) of the Act means a finding of guilt of a criminal offence by a court in the United Kingdom. This definition includes a finding of guilt following either a guilty plea or a trial and irrespective of any sentencing by the court. Convictions should be considered using the staged approach outlined in paragraph 19.

145. Cautions, conditional cautions and other out-of-court disposals administered by the Police or other enforcement authorities are not convictions within the Act, but may still be considered to amount to UPC under section 20(2) of the Act. These should be considered using the staged approach outlined in paragraph 16.

146. Convictions arising in other jurisdictions, including Crown Dependencies, are not convictions within the Act, but may still be considered to amount to UPC under section 20(2) of the Act. These should be considered using the staged approach outlined in paragraph 16.

Finding of fact of the conviction

147. If the PCC receives in evidence a signed certificate of the conviction, then it must accept the certificate as conclusive evidence of the offence having been committed, unless it also receives evidence to the effect that the chiropractor is not the person referred to in the conviction.[19]

Finding of material relevance of the conviction

148. The purpose of considering a conviction is not to punish the chiropractor for a second time. The PCC is concerned with the over-arching objective to protect the public, and the three limbs set out in paragraph 11.

[19] General Chiropractic Council (Professional Conduct Committee) Rules 2000, Rule 7(1) Ref5

149. The material relevance of the conviction to the fitness to practise of the chiropractor is a matter for the judgement of the committee, not a matter of proof. The committee may consider and take due account of aspects of the case including (but not limited to)

a) the nature and gravity of the offence;
b) the nature and severity of the sentence;
c) any mitigating or aggravating circumstances;
d) how a fair-minded and informed member of the public would view the conduct.

150. In a hearing about a conviction, the GCC case presenter will be invited to put forward evidence about the circumstances leading up to the conviction and the character and previous history of the respondent chiropractor. The chiropractor will then have the opportunity to address the committee by way of mitigation and present any evidence.

151. Where multiple convictions arise from or materially contribute to another (e.g. drink-driving leading to careless driving causing serious injury), there is a strong public interest in considering them together, to avoid understating seriousness.

152. Convictions resulting in an absolute or conditional discharge are unlikely to be considered materially relevant, but the seriousness will be fact specific (for instance if the offence took place in the course of their professional practice).

153. Convictions for offences involving drugs or alcohol (including drink driving) are likely to be considered materially relevant, but the seriousness will be fact specific.

154. The committee may decide to take no further action if it finds that a conviction has no material relevance to the fitness of the chiropractor to practise [20]. In this case no action is taken and the chiropractor is informed of this outcome. The committee must give full reasons for the decision in its written determination.

155. However, the committee may decide that a conviction has material relevance to the fitness of the chiropractor to practise even if the offence occurred in the chiropractor's private life, rather than in the course of their professional practice, as such convictions may impact upon public confidence in the profession.

Which is the appropriate sanction?

156. Where a committee finds that a conviction is proven and materially relevant, then the committee must impose a sanction (there is no option not to apply a sanction).[21]

157. PCCs should bear in mind different considerations will be relevant to the criminal court when imposing a sentence for the offence. For example, there may have been specific personal mitigation which led the court to its decision on sentence which, in the regulatory context, carries less weight due to the need to maintain public confidence in the profession. However, committees may take into account comments made in sentencing remarks where those comments are relevant to its decision on sanction.

[20] Chiropractors Act (1994) Section 22(3) Ref1
[21] Chiropractors Act (1994) Section 22(4) Ref1

158. When a chiropractor has been convicted of a serious criminal offence, it will generally not be consistent with the overarching objective for them to return to unrestricted practice until they have completed their criminal sentence. However, a PCC must always ensure the sanction it imposes is just, proportionate and only that which is necessary to fulfil the overarching objective, including the maintenance of public confidence.

Sexual Misconduct

159. Sexual misconduct is particularly serious because it may have a significant impact on the complainant (or person being harmed or at risk of harm) and it is likely to gravely undermine the trust and confidence the public places in the profession.

160. Sexual misconduct covers a wide range of conduct, which may include:

a) criminal convictions for sexual offences (including child sexual exploitation);
b) possessing, viewing or distributing child sexual abuse material;
c) sexual harassment;
d) other unacceptable sexual behaviour;
e) pursuing an inappropriate sexual relationship.

161. The PCC should take account of the relevant values, principles and standards set out in the Code of Professional Practice Ref2 (including Principle E ¥ and Standard E1 ¥) and the relevant expectations within the Guidance for Registrants (including Guidance for Registrants: Professional Boundaries).

162. Sexual misconduct does not need to be sexually motivated – it can have the effect of threatening, intimidating, offending, undermining, humiliating or coercing a person or group.

163. Abuse of a professional position to pursue a sexual relationship is likely to be considered serious. It is the chiropractor's responsibility to prevent sexual boundaries being crossed, not the patient's.

164. Conduct which leads to a chiropractor being placed onto the Sex Offenders Register, Children's Barred List or Adult's Barred List is also likely to be regarded as particularly serious and may be incompatible with any form of practice.

165. In cases of serious sexual misconduct it will be highly likely that the only proportionate sanction will be removal from the register. This is because such conduct is likely to gravely undermine trust and confidence in the profession. However, each case will be considered on its own facts. If a PCC decides to impose a sanction other than removal, it will need to fully explain that decision.

Dishonesty and lack of integrity

166. Dishonesty, even when it does not result in direct harm to patients, is particularly serious because it is likely to gravely undermine the trust and confidence the public places in the profession. This includes dishonesty that occurs entirely outside the chiropractor-patient relationship; for example giving false statements or making fraudulent claims for money.

167. Dishonesty and lack of integrity are linked, but separate, aspects of conduct. Examples of dishonesty or lack of integrity in professional practice may include:

a) defrauding a partner in the practice;
b) falsifying or improperly amending patient records;
c) submitting or providing false references, or inaccurate or misleading information on a CV;
d) failing to take reasonable steps to ensure that statements made in formal documents are accurate;
e) providing inaccurate information to the GCC or another organisation when required to (including regulator, insurer, professional body or employer). For example, not disclosing a criminal conviction or offence when required to;
f) dishonesty in the context of conducting or presenting research
g) making false medical claims

168. The PCC should take account of the relevant values, principles and standards set out in the Code of Professional Practice Ref2 (including Principle C ¥ and Standards C9 ¥, C11 ¥, A2 ¥, D15 ¥) and the relevant expectations within the Guidance for Registrants.

169. Factors which the PCC may wish to consider when assessing the dishonest conduct include:

a) the duration of any dishonesty;
b) whether the dishonesty was an isolated instance or forms part of a pattern of behaviour;
c) whether the dishonesty was admitted and, if so, whether that was at the first opportunity or whether the dishonesty was hidden for a time;
d) whether the dishonesty was motivated by personal gain.

170. The most serious instances of dishonesty in professional practice are those which either directly harm patients or have the potential to put patients at risk of harm.

171. Dishonesty in the context of a chiropractor's private life is still likely to have a significant impact on public confidence in the profession. An example could be a criminal conviction for fraud.

172. Conduct demonstrating a lack of integrity may still have the potential to place patients at risk of harm.

173. Factors which the PCC may wish to consider when assessing a lack of integrity may include:

a) the duration of the conduct;
b) whether the lack of integrity was an isolated instance or forms part of a pattern of behaviour;
c) whether the lack of integrity was admitted and, if so, whether that was at the first opportunity or whether the lack of integrity was hidden for a time;
d) whether the lack of integrity was motivated by personal gain.

174. Dishonesty in the context of research is serious as it has the potential to have far-reaching consequences. Research misconduct ranges from presenting misleading information in publications through to dishonesty in clinical trials. This behaviour undermines the trust that both the public and the profession have in chiropractic as a science, whether or not this leads to direct harm to individual patients.

175. Dishonest conduct, or conduct demonstrating a lack of integrity, may be harder to remediate. Evidence of professional competence cannot mitigate serious or persistent dishonesty. Acting dishonestly is highly damaging to public confidence in the chiropractic profession. It is therefore likely to warrant a more serious sanction and a PCC will need to carefully consider whether a sanction other than removal is proportionate.

Failing to provide an acceptable level of treatment or care

176. Failing to provide an acceptable level of treatment or care is particularly serious because it may have a significant impact on the complainant (or person being harmed or at risk of harm) and it is likely to gravely undermine the trust and confidence the public places in the profession.

177. The PCC should take account of the relevant values, principles and standards set out in the Code of Professional Practice Ref2 (including Principle A ¥, Principle B ¥ and Principle D ¥) and the relevant expectations within the Guidance for Registrants (including Guidance for Registrants: Duty of Candour).

178. Committees are likely to find particularly serious any case where the chiropractor shows a reckless disregard for patient safety or where there is a breach of the fundamental duty of chiropractors to protect the patient from harm.

179. Factors which the PCC may wish to consider when assessing clinical failings include:

a) the nature and seriousness of the clinical failing;
b) the harm or risk of harm presented by the failing;
c) any evidence of repetition or frequency of the failing;
d) whether the failing was an isolated lapse in judgement;
e) whether there was a remediable deficiency in knowledge or skills;
f) an objective assessment of the competence of the chiropractor;

180. A particularly important consideration in such cases is whether or not a chiropractor has, or has the potential, to develop insight into these failures, and if the clinical failings could be addressed through training or other learning. If this is not evident, it is likely that a Conditions of Practice Order or Suspension Order may not be sufficient.

Discrimination and harassment

181. Discrimination will be treated seriously because it may have a significant impact on the complainant (or person being harmed or at risk of harm) and is likely to damage public confidence in the chiropractic profession - particularly among groups who already experience barriers to accessing care.

182. Unlawful discrimination means treating a person unfairly because of their protected characteristics under the Equality Act (2010) [22]. The protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

183. The PCC should take account of the relevant values, principles and standards set out in the Code of Professional Practice Ref2 (including Principle A ¥, Principle B ¥, Principle G ¥ and Principle H ¥ and Standards A5 ¥, B5 ¥, C13 ¥, E2 ¥, G6 ¥) and the relevant expectations within the Guidance for Registrants (including Guidance for Registrants: Professional Boundaries).

184. Discrimination can take many forms, including both direct and indirect discrimination as well as harassment and victimisation. It may occur in either a chiropractor's professional or personal life.

185. A committee may encounter cases based on discrimination, even where it is not unlawful under the Equality Act (2010) Ref6. Whether the discrimination is unlawful may be relevant to the Committee's assessment of seriousness. Discrimination not based on a protected characteristic (for example socio-economic factors), particularly where patients are treated less favourably or denied treatment, may be considered serious.

186. The Committee should have regard to widely recognised definitions of specific hatred towards others to assist them in establishing whether something amounts to discrimination for example antisemitism; anti-muslim hostility; racism; sexism; homophobic, biphopic or transphobic hate.

187. Committees will consider carefully the impact of the conduct. This may include adverse effects on the physical and emotional wellbeing of the complainant (or person being harmed or placed at risk of harm). It may also create or exacerbate barriers to the ability or willingness of certain groups to access care.

188. In cases where unlawful discrimination has been directed towards other healthcare professionals, there may be harm caused to those professionals and a risk to the provision of safe patient care where the conduct impacts upon the ability of professionals to work together effectively.

189. Where unlawful discrimination occurs in a chiropractor's private life, that is still something the committee is likely to take seriously given the risk to public confidence in the profession.

[22] Equality Act (2010) Sections 4 and 13-27.Ref6

Exploitation of vulnerability and victimisation

190. Exploitation of vulnerability and victimisation will be treated seriously because it may have a significant impact on the complainant (or person being harmed or at risk of harm) and is likely to damage public confidence in the chiropractic profession - particularly among groups who already experience barriers to accessing care.

191. The PCC should take account of the relevant values, principles and standards set out in the Code of Professional Practice Ref2 (including Principle A ¥, Principle B ¥, and Principle E ¥ and Standards A3 ¥, A6 ¥, B2 ¥, C8 ¥, C12 ¥, C13 ¥, F2 ¥, F3 ¥, F5 ¥,) and the relevant expectations within the Guidance for Registrants (including Guidance for Registrants: Professional Boundaries).

192. Many people accessing the services of chiropractors will feel vulnerable to some extent. It is important that a committee considers a person's full circumstances before reaching a view on the extent of any vulnerability.

193. Examples of factors that may make a person more vulnerable include:

a) having impaired capacity to make certain decisions;
b) being a child or young person under the age of 18;
c) disability;
d) frailty;
e) dependency on the chiropractor;
f) a history of abuse or neglect.

194. Where a person is assessed as being vulnerable, a chiropractor is likely to have an even greater obligation to consider their welfare and not act in a way which exploits their vulnerability.

195. Often the pursuit of inappropriate relationships, whether or not involving sexual misconduct, will be based upon the exploitation of a person's vulnerability. Inappropriate emotional, romantic or otherwise exploitative relationships may be regarded as inherently serious, even where the underlying conduct does not fall into another category of this guidance (such as dishonesty or sexual misconduct).

196. In assessing seriousness, the committee will consider carefully any direct impact of exploitation on the person being harmed or at risk of harm, the degree of any power imbalance or abuse of trust and the risk to public confidence in the profession.

Review Hearings

Purpose of a review hearing

197. When a committee decides that a period of registration with conditions or suspension is appropriate, it will normally order that a review hearing be held, because the committee will want to ensure that the chiropractor is fit to resume practice before the order lapses.

198. Where a review has been directed, it is important that no chiropractor should be allowed to resume unrestricted practice following a period of conditional registration or suspension unless the committee considers that they are safe to do so.

How a review hearing may arise

199. A review hearing will arise at any point prior to the expiry of an order in the following circumstances:

a) A review hearing has been ordered by the committee imposing the original (or subsequent) sanction order;
b) A review hearing has been ordered, but circumstances arise which mean the GCC or chiropractor consider it is necessary to hold a hearing earlier than scheduled. Either party may request an earlier hearing.
c) A review hearing has not been ordered, but a change in circumstances leads the GCC or the chiropractor to consider that it is necessary for the sanction to be reviewed. Either party may request an earlier hearing. In this case the committee's original reasons for not directing a review may be relevant to any decision that is then taken.

200. Note that there is a restriction on when a chiropractor may request a review of a sanction imposed by the Health Committee when a previous application was refused.

Approach of the reviewing committee

201. At review hearings, the committee will need to consider and make a finding as to whether the chiropractor has complied with any conditions imposed at the previous hearing and give reasons for its decision. The committee must do this before deciding whether or not to impose a further order.

202. The committee will need to be reassured that the chiropractor is fit to resume practice either unrestricted, or with some form of restraint.

203. The committee will take the following approach to a review hearing:

a) remind itself of the findings of previous hearing(s) and the purpose of the existing order;
b) consider compliance with any conditions imposed at a previous hearing, taking account of any evidence provided;
c) consider the chiropractors fitness to resume practice, taking account of any evidence provided;
d) consider the appropriate options available to the committee on review.

204. When considering the chiropractor's fitness to resume practice, the committee will need to satisfy itself, as relevant, that:

a) the chiropractor fully appreciates the gravity of the conduct;
b) the chiropractor has not repeated the conduct;
c) the chiropractor has maintained their skills and knowledge or reached a satisfactory level of competence;
d) (in health cases) the chiropractor's ability to practise is no longer seriously impaired by a mental or physical health condition;
e) patients will not be placed at risk by resumption of unrestricted practice or (where legally available) practice with conditions.

205. The committee should consider whether the chiropractor has produced any evidence on these matters and will carefully consider the quality of that evidence.

Reviewing orders following a conviction in the United Kingdom of a criminal offence

206. When reviewing orders where the chiropractor has been convicted of a criminal offence, the committee will consider whether any sentence has been served and whether at the time of the review they appear in the Sex Offenders' Register, Children's Barred List or Adult's Barred List.

Reviewing orders made by the Health Committee

207. When reviewing orders made by the Health Committee, it is likely the committee will wish to see up-to-date medical evidence about the chiropractor's health and how they are managing their condition.

Options available to a review committee

208. The options available to a committee at a review hearing vary depending on whether the case is before the PCC or HC and the order being reviewed.

209. When extending or varying an order, or imposing a new order, the review committee's written determination must provide clear and cogent reasons for their actions (as if applying a sanction for the first time), including consideration of any conditions, proportionality and duration.

Reviewing a Conditions of Practice Order imposed by the PCC

210. At any time when a Conditions of Practice Order is in force, the PCC may (whether or not of its own motion)[23]:

a) extend, or further extend, the period for which the order has effect;
b) revoke or vary any of the conditions;
c) require the chiropractor to pass a test of competence specified by the Committee;
d) reduce the period for which the order has effect; or
e) revoke the order.

211. Where the PCC extends or reduces the Conditions of Practice Order, or specifies a test of competence, the order will have effect as if [24]:

a) the period specified in the Conditions of Practice Order was the extended or reduced period; and
b) a test of competence was specified in that Order.

Reviewing a Suspension Order imposed by the PCC

212. At any time when a Suspension Order is in force, the PCC may (whether or not of its own motion) [25]:

a) extend, or further extend, the period for which the order has effect;
b) make a Conditions of Practice Order with which the chiropractor must comply if they resume the practice of chiropractic after the end of the period of suspension.

Reviewing a Conditions of Practice Order imposed by the HC

213. At any time when a Conditions of Practice Order imposed by the HC is in force, the HC may (whether or not of its own motion) [26]:

a) extend, or further extend, the period for which the order has effect;
b) make a Suspension Order

214. On the application of the chiropractor with respect to whom a Conditions of Practice Order is in force the HC may[27]:

a) revoke the Order;
b) vary the Order by reducing the period for which it has effect; or
c) vary the Order by removing or altering any of the conditions.

[23] Chiropractors Act (1994) Section 22(7) Ref1
[24] Chiropractors Act (1994) Section 22(8) Ref1
[25] Chiropractors Act (1994) Section 22(9) Ref1
[26] Chiropractors Act (1994) Section 23(4) Ref1
[27] Chiropractors Act (1994) Section 23(6) Ref1

Reviewing a Suspension Order imposed by the HC

215. At any time when a Suspension Order imposed by the HC is in force, the HC may (whether or not of its own motion)[28]:

> a) extend, or further extend, the period of suspension;
> b) replace the order with a Conditions of Practice Order having effect for the remainder of the period of suspension; or
> c) make a Conditions of Practice Order with which the chiropractor must comply if they resume the practice of chiropractic after the end of the period of suspension.[29]

216. On the application of the chiropractor with respect to whom the Suspension Order is in force, the HC may:

> a) revoke the Order;
> b) vary the Order by reducing the period for which it has effect.

Restriction on requesting a review of a sanction imposed by the HC

217. Where a chiropractor makes an application which is refused, the HC shall not entertain a further such application unless it is made after the end of the period of twelve months beginning with the date on which the previous application was received by the HC.[30]

Adjourned or unfinished reviews

218. If a review hearing cannot be finished before the end of the period of conditional registration or suspension, the committee may extend that period for a further short period. This is to allow for a review hearing to continue as soon as practicable, while keeping the conditions or suspension in force until the outcome. The committee should ask both parties to confirm when they will be ready to resume the hearing and take that into account when deciding on the period of extension.

Further reviews

219. Where a reviewing committee imposes a further sanction, it should consider whether or not to direct a further review hearing be held. In most cases a further review hearing will be necessary, because the committee will again want to check the chiropractor's compliance with the order before it expires. Where a committee decides not to direct a review hearing be held, it must give reasons explaining the basis of the decision not to direct that a review hearing be held.

[28] Chiropractors Act (1994) Section 23(5) Ref1
[29] Chiropractors Act (1994) Section 23(6) Ref1
[30] Chiropractors Act (1994) Section 23(7) Ref1

Interim Suspension Orders

220. The committee has the power to order the Registrar to suspend the registration of a chiropractor with immediate effect where it decides to suspend or remove the chiropractor from the register, if it is satisfied that this is necessary to protect members of the public. This prevents the chiropractor from practising during the 28-day period in which they can appeal the sanction and until any appeal has been decided. This is called an Interim Suspension Order ('ISO').

221. The power to impose an ISO is discretionary, and so committees should not consider it to be an automatic outcome.

222. Chiropractors or their representatives may argue that no ISO should be made, as the chiropractor needs time to arrange for the care of their patients before the substantive order for suspension or removal from the register takes effect. In considering such arguments, the committee will need to bear in mind its reasons for imposing a particular sanction, and that the purpose of ISOs is to protect the public and the wider public interest. The committee will also wish to take account of the fact that any chiropractor whose case is being considered by a committee will have been aware of the date of the hearing for some time so should have had sufficient time to plan for the possibility of a Suspension Order or Removal Order (and an ISO) being made.

223. If it is considered necessary to suspend or remove a chiropractor from the register, interim suspension should always be considered as the committee may conclude that it follows from its sanction decision that an ISO is necessary to protect the public during the appeal period. The decision about whether or not to impose an ISO is one that the committee will approach based on the individual facts of the case.

Health Committee

224. As explained in paragraph 15 (The nature of allegations), allegations concerning a chiropractor's physical or mental health will be referred to the Health Committee (HC) and allegations of any other kind will be referred to the PCC.

225. Where the HC is satisfied an allegation is well-founded, they must impose either a Conditions Order or a Suspension Order.[31]

226. The purpose of this section of the guidance is to:

> a) Explain the decision-making process of the HC; and
> b) Highlight some of the nuances around such orders where they are imposed and being considered on review by a HC, rather than a PCC.

227. HCs will still have regard to all sections of this guidance, so far as they are relevant; in particular: 'Approach to sanctions and reasons' and Allegations of serious impairment due to the chiropractor's physical or mental condition.

The Sanctions Available to the Health Committee

Conditions of Practice Order (Health)

228. Where the HC imposes a Conditions of Practice Order, it has effect for the term specified in the Order[32], and may be imposed for up to three years in the first instance. There is no provision in the Act for the HC to specify a test of competence.

229. If the HC has found a chiropractor's ability to practise to be impaired due to their physical or mental condition, the Conditions of Practice Order should include conditions that relate to medical supervision of the chiropractor, as well as some relating to practice if considered necessary to fulfil the over-arching objective.

230. Generally, it is not appropriate to impose conditions that include a requirement for medical supervision unless the chiropractor's ability to practise has been found impaired because of their physical or mental health. An exception may be a case where a chiropractor has refused to undergo a health assessment or has a conviction relating to drug or alcohol abuse.

231. In considering whether a Conditions of Practice Order is the proportionate sanction, HCs will consider paragraphs 46 to 57 (Conditions of Practice Order) of the guidance, as relevant, in assessing:

> a) Whether conditions are appropriate;
> b) How to formulate conditions (including using the Conditions Bank); and
> c) Considering whether to order a Review Hearing.

[31] Chiropractors Act (1994) Section 23(2) Ref1
[32] Chiropractors Act (1994) Section 23(5) Ref1

Ordering a Review Hearing when imposing a conditions of Practice Order

232. When imposing a Conditions of Practice Order, the committee should consider if they wish for it to be reviewed prior to its expiry. The committee can order a Review Hearing to consider whether the chiropractor is fit to resume practice before the Order expires.

233. When ordering a review, the committee should be clear as to the purpose of the order and the evidence that would likely assist the reviewing committee to assess compliance with the conditions.

234. If the committee does not consider that a review hearing is necessary, it should clearly explain its reasons in its determination.

235. There are more details about Review Hearings and the options available to the committee when reviewing a sanction when reviewing a sanction at paragraphs 197 – 219 of this guidance.

Suspension Order (Health)

236. A HC may impose a Suspension Order for up to three years.

237. Suspension Orders may be appropriate when the chiropractor's health is such that the committee is not satisfied that the chiropractor can practise safely even if conditions were to be imposed. In such cases, the HC is likely to wish to direct a review hearing in order to ensure that up to date information about the chiropractor's health is available to the reviewing committee to enable it decide whether the chiropractor is then fit to resume practice, either under conditions or unrestricted.

238. When considering whether a Suspension Order is the proportionate sanction, HCs will consider paragraphs 64-72 of the guidance (Suspension Order).

Protecting the public before a Suspension Order comes into effect

239. In cases when the HC decides to impose a Suspension Order, the committee will consider whether it is necessary to impose an Interim Suspension Order to protect members of the public during the period until the Suspension Order comes into effect[33].

240. As with PCCs, a sanction imposed by the HC does not take effect for 28 days and, if an appeal is lodged, not until that appeal has been decided, during which time the chiropractor would remain on the register and be able to practise, if an Interim Suspension Order has not also been imposed.

241. Further detail on Interim Suspension Orders is contained above in paragraphs 222-230.

[33] Chiropractors Act (1994) Section 24(2) Ref1

Ordering a Review Hearing when imposing a Suspension Order

242. When imposing a Conditions of Practice Order, the committee should consider if they wish for it to be reviewed prior to its expiry. The committee can order a Review Hearing to consider whether the chiropractor is fit to resume practice before the Order expires.

243. When ordering a review, the committee should be clear as to the purpose of the order and the evidence that would likely assist the reviewing committee to assess compliance with the conditions.

244. If the committee does not consider that a review hearing is necessary, it should clearly explain its reasons in its determination.

245. There are more details about Review Hearings and the options available to the committee when reviewing a sanction when reviewing a sanction at paragraphs 197 – 219 of this guidance.

References

1. **The Chiropractors Act 1994** *(Accessed September 2026)* https://www.legislation.gov.uk/ukpga/1994/17/contents

2. **The Code of Professional Practice** - General Chiropractic Council (GCC) (2026). *(Accessed September 2026).* https://www.gcc-uk.org/COPP

3. **Publication and Disclosure Policy** - General Chiropractic Council (GCC) (2020). *(Accessed September 2026)* https://www.gcc-uk.org/assets/publications/Publication_and_Disclosure_Policy.pdf

4. **Conditions Bank** - General Chiropractic Council (GCC) (2026). *(Accessed September 2026)* https://www.gcc-uk.org/assets/publications/Conditions_Bank_2026_EN.pdf

5. **The General Chiropractic Council (Professional Conduct Committee) Rules Order of Council 2000** *(Accessed September 2026)*: https://www.legislation.gov.uk/uksi/2000/3290/contents

6. **Equality Act 2010** *(Accessed September 2026):* https://www.legislation.gov.uk/ukpga/2010/15/contents

Other Relevant Legislation, Rules, Guidance and Policies

- **The General Chiropractic Council (Health Committee) Rules Order of Council 2000** *(Accessed September 2026)*: https://www.legislation.gov.uk/uksi/2000/3291/contents

- **The General Chiropractic Council (Professional Conduct Committee and Health Committee) Amendment Rules Order of Council 2006** *(Accessed September 2026)*: https://www.legislation.gov.uk/uksi/2006/1630/contents

- **Hearings Protocol** – General Chiropractic Council, (2026), *(Accessed September 2026)*: https://www.gcc-uk.org/assets/publications/Hearings_Protocol_2026_EN.pdf

- **Remote Hearings Protocol** – General Chiropractic Council, (2026), *(Accessed September 2026)*: https://www.gcc-uk.org/assets/publications/Remote_Hearings_Protocol_2026_EN.pdf

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General Chiropractic Council

GCC Guidance on Sanctions:

Equality Impact Assessment

and Welsh Language Impact Assessment

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GCC Guidance on Sanctions

November 2026

GCC Guidance on Sanctions –
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 GCC Guidance on Sanctions
Is a new or existing policy/activity?
Replacement of existing policy
What is the main purpose and what are the intended outcomes of the policy/activity?

• The work is intended to update the principles that practice committee panels (panels) should consider when deciding on the appropriate sanction, if any, in fitness to practise (FTP) cases. It is also intended to provide more clarity on the policy and to ensure the content is relevant and up to date. We are reviewing and updating our guidance to ensure it remains relevant, comprehensive, and aligned with the new Code of Professional Practice.
• The existing GCC Guidance on Sanctions was published in April 2018 and requires updating to align with the new Code of Professional Practice (2026) and the revised expectations of the public and GCC of the profession.
• Our preparatory work identified that the existing guidance did not reflect recent case law.
• The existing guidance did not reflect as an aggravating factor:
  ○ the seriousness of conduct that could amount to discrimination, harassment, or victimisation on the basis of any protected characteristic—including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation
  ○ the seriousness of sexual misconduct (except in the specific case of conduct intended to “initiate or pursue a sexual relationship”).

Who is most likely to benefit or be affected by the policy/activity
The guidance is intended to be used by members of the Health and Professional Conduct Committees when considering appropriate sanctions to impose. It will directly affect chiropractors who have 1. been found guilty of conduct which falls short of the standard required of a registered chiropractor (defined as "unacceptable professional conduct" (“UPC”) 2. been found guilty of professional incompetence;

3. been convicted (at any time) in the United Kingdom of a criminal offence;
4. been found (by the Health Committee) that their ability to practise as a chiropractor is seriously impaired because of their physical or mental condition.

Patients will also benefit through sanctions guidance that requires the committee to impose a sanction that is sufficient to protect patients.

Other users of the guidance may include:

- Legal Representatives
- Registrants and potential registrants
- Education and training providers

Who is doing the assessment?	
Hannah Fellows, Fitness to Practise Director Andrew Fielding, Policy and Insights Officer	
Dates of the Assessment	
• When did it start?	April 2026
• When was it completed?	November 2026
• When should the next review of the policy/activity take place?	Further review post implementation.

Useful Information

What information would be useful to assess the impact of the policy/activity on equality?
We need informed views about whether the proposed guidance unfairly disadvantages stakeholders with protected characteristics. Currently, we do not have any data which suggests that people with particular protected characteristics will be negatively impacted because of this guidance, however the consultation into the proposed guidance in Summer 2026 has provided further insight into how the guidance may impact equality. The document has benefitted from this process and been updated where appropriate. Once finalised, the impact of the guidance will be monitored over time.

Is there data relating to people with any/each of the protected characteristics?[1]
Registrants The GCC registrant database has provided us with information regarding the distribution of the protected characteristics of our registrant population. We have considered (as appropriate) findings of the Attitudes to EDI survey (Summer 2023) and the GCC Registrant Survey 2020 (main report and EDI report). We have considered two internal reports - the Investigating Committee thematic review of EDI carried out in 2022, and the EDI Thematic Review of the Professional Conduct Committee carried out in 2024. The IC Thematic Review (2022) found that males, and registrants aged 45-64, were overrepresented in the number of concerns. As the FTP process progresses, it becomes harder to robustly identify statistical patterns in FTP outcomes due to smaller datasets. However we acknowledge that chiropractors that are subject to a sanction from the Health Committee, by definition, are likely to have a long-term health condition or disability. **Patients** We do not have data on the protected characteristics of chiropractic patients, but have considered UK Census statistics[2]. We note that patient witnesses are likely to be vulnerable due to a variety of reasons but also by the nature of the process and previous patient/professional power imbalance
Where can we get this information and who can help?
Registrants During the consultation process into the guidance we will specifically seek the views of chiropractors who are living with a long-term illness or disability. We will continue to seek feedback from external stakeholders including professional bodies, the RCC, other regulators and the legal representatives through our standing meetings and on an ad-hoc basis where necessary.

[1] The nine protected characteristics in the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Section 14 of the act also identifies overlapping protected characteristics as protected. The Equality Act 2010 only applies to England, Wales and Scotland.

The same characteristics are protected by similar legislation in Northern Ireland (Section 75 of the Northern Ireland Act 1998 covers public bodies, but other legislation covers provision of goods and services), the Isle of Man (The Equality Act (2017)) and Gibraltar (The Equality Act (2006)). The legislation in Northern Ireland additionally identifies Political Opinion and having (or not having) children as protected characteristics when dealing with public bodies.

[2] Office for National Statistics (England and Wales), National Records of Scotland and Northern Ireland Statistics and Research Agency.

Patients

We will look to identify appropriate methods to further consider the impact on patients – including through secondary research and encouraging patient and public responses to the consultation.

Step 2 – Evidence and Engagement

If you have involved stakeholders, briefly describe what was done, with whom, when and where.

During the consultation phase a communication plan was developed to:

- create awareness and understanding of the sanctions guidance among stakeholders
- share and disseminate information in a timely fashion
- encourage stakeholders to provide meaningful input into the decision-making process
- generate new ideas to be considered and evaluated throughout the process.

The external stakeholder groups targeted successfully included:

- Professional bodies
- Registrants
- An advisory group of registrants with experience of living with a disability or health condition
- Legal representatives for chiropractors
- GCC partners

Despite our best efforts, we acknowledge there was limited engagement from

- Education providers
- Patients and patient interest groups

The GCC has published an accompanying consultation response with further details.

<u>Limitations of the evidence base</u>

The availability and quality of evidence varies across protected characteristics. In some areas, particularly where case numbers are low or equality data is incomplete, it is difficult to draw robust conclusions about differential impacts. The absence of identified adverse impacts should not be interpreted as evidence that no impacts exists.

The GCC will continue to monitor the implementation of the guidance and consider future evidence, research and stakeholder feedback to identify any unintended consequences.

Step 3 – Analysis by protected characteristic

The nature of the Guidance on Sanctions means that there are two lenses (relating to discrimination, disadvantage and protected characteristics) that should be considered:

- The role of the guidance in protecting patients and the public from discriminatory conduct (through the enforcement of sanctions);
- The application of the guidance to prevent discrimination or bias, or provide support, in relation to the chiropractor or others involved in the hearing.

Patients and the Public
The guidance is clear that discrimination will be treated seriously because it may have a significant impact on the complainant (or person being harmed or at risk of harm) and is likely to damage public confidence in the chiropractic profession - particularly among groups who already experience barriers to accessing care.

It highlights various forms and circumstances of discrimination and is clear that they all may amount to UPC. The guidance will support consistent decision-making by directing panels to recognise the harm caused by discriminatory conduct not only to individual patients, colleagues or the public, but also to the confidence or willingness of certain groups to access care.

Registrants (and other participants in the hearing).
The guidance reinforces the need to take proper account of context and protected characteristics, so that decisions are fair, evidence-based and free from bias.

The guidance highlights areas where the context of a protected characteristic may be relevant to assessing evidence and submissions – in particular when assessing insight and remediation, when providing references or testimonials, and in cases where a chiropractor is unrepresented (which may be associated with a protected characteristic).

Providing accommodations (to assist where a participant requires support to give evidence) is mostly outside of the scope of this guidance – but is addressed within the legislation, rules, guidance and policies relevant to the fitness to practice process.

When a sanction is required, the impact of that sanction on the individual may vary depending on their personal circumstances, including protected characteristics, health needs, caring responsibilities or other relevant factors. The guidance therefore emphasises the importance of ensuring that the sanction is the least restrictive option that is necessary to protect the public, and committees should take account of relevant individual circumstances when determining and reviewing sanctions to avoid unintended disadvantage while maintaining public protection and confidence in the profession.

Although much of the analysis focuses on registrants and patients, the fitness to practise process also involves complainants, witnesses, representatives, committee members and other. The principles within the guidance, including fairness, proportionality, consideration of context and appropriate support for participants, are intended to contribute to an accessible process for all those involved. The GCC will continue to consider the needs of different participant groups when reviewing the operation of the guidance and the wider PCC and HC processes.

Age
(include children and adults)

Registrants

Age, “experience” and “stage of career” are likely to be strongly correlated concepts.

There is some evidence from the IC thematic review that older registrants are more likely to be subject to FTP concerns. The data in the PCC Thematic Review was insufficient to draw conclusions on age disparity at sanction, but other health regulators have identified a pattern in their own FTP data of older registrants being more likely to receive a sanction.

The guidance promotes consistent decision making by focusing on the objective consideration of the competence of the chiropractor, and their insight and ability to remediate, rather than considering “experience” as a factor.

The guidance addresses when it is appropriate to consider the “stage of a chiropractor’s career” as a mitigating factor (for instance when they were inexperienced but has subsequently been able to reflect on how they would do things differently) and when it is not.

Patients and the public

Child sexual exploitation and possession of child sexual abuse material are specifically identified as conduct that is highly likely to result in removal from the register.

The guidance specifically identifies that the age of a patient (under 18), or the frailty of a patient are factors contributing to vulnerability. Exploitation of vulnerability and victimisation will be treated seriously because of the significant impact it will have on the patient.

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).

Registrants

Although not statistically robust due to small numbers, the PCC Thematic Review (2024) found that chiropractors with disabilities have a slightly higher proportion of UPC findings (5 out of 9 cases reviewed) compared with those without disabilities (19 out of 41 cases).

In addition, chiropractors receiving a sanction from the Health Committee will, by definition, have a disability, illness or long-term health condition.

The staged approach to decision making for the Health Committee makes it clear that the GCC must prove that the chiropractor’s ability to practise is seriously impaired as a result of their condition – not just that they have a condition.

When reviewing conditions of practice orders and suspensions imposed by the Health Committee, the focus is again on the chiropractor’s ability to practise safely, not on whether they have, or do not have, a health condition.

Finally there is guidance on when it is, and is not, appropriate to consider medical conditions when imposing a conditions of practice order.

More widely, the PCC and HC are reminded of the impact of health and neurodiversity on the chiropractor's expression or demonstration of insight and remorse. The guidance reminds the committee that awareness of, and sensitivity to, these issues are important in considering and assessing the degree of insight or remorse shown.

Patients and the public

The guidance directs that disability discrimination will be treated seriously because it may have a significant impact on the complainant (or person being harmed or at risk of harm) and is likely to damage public confidence in the chiropractic profession.

The guidance specifically identifies that the frailty or disability of a patient are factors contributing to vulnerability. Exploitation of vulnerability and victimisation will be treated seriously because of the significant impact it will have on the patient.

Gender reassignment
(consider that individuals at different stages of transition may have different needs)

Registrants

The guidance recognises that the communication of evidence and remorse may be influenced by factors including gender (which may include gender presentation).

The committee is expected to evaluate the weight given to any evidence in terms of the circumstances of the case and the extent to which it assists the committee in assessing the chiropractor's insight and remediation. They are expected to test and corroborate evidence where it is significant to a decision on sanctions, and to be mindful not to draw a negative conclusion from an absence of evidence.

Patients and the public (including colleagues)

Research from the TUC in 2019 suggests that people who are trans or non-binary are disproportionately targeted by inappropriate sexual behaviour in the workplace.

The guidance specifically highlights that sexual misconduct does not need to be sexually motivated, and can have the effect of threatening, intimidating, offending, undermining, humiliating or coercing a person or group. Sexual misconduct is considered very serious and it is highly likely that the only proportionate sanction will be removal from the register.

More widely the guidance directs that discrimination will be treated seriously because it may have a significant impact on the complainant and is likely to damage public confidence in the chiropractic profession. The guidance specifically addresses hatred towards others (including transphobic hate) even where the discrimination is not unlawful.

Marriage and civil partnerships
(include same-sex unions)

Registrants

The revised guidance specifically highlights the scenario of a chiropractor under investigation choosing not to request testimonials or references from family members (which would include a spouse). The committee is advised not to draw adverse conclusions if a chiropractor has chosen not to present a reference or testimonial.

The guidance reminds the committee that awareness of and sensitivity to these issues are important in considering and assessing the degree of insight or remorse shown.

Patients and the public

The latest figures from the Office for National Statistics highlight the prevalence of domestic abuse within the UK – estimating that 2.2 million females (9.1%) and 1.5 million males (6.5%) experienced domestic abuse in the last year.

The guidance seeks to protect victims of domestic abuse and coercive control where the perpetrator is a chiropractor, by stating that conduct in the chiropractor's private life (rather than during their professional practice) can be considered serious. The guidance specifically highlights as aggravating or serious conduct that abuses a position of trust, abuses vulnerability or harasses or victimises another. The guidance on criminal convictions (which would include domestic abuse convictions) specifically also highlights that convictions for an offence that occurred in the chiropractor's private life may also have material relevance to their fitness to practise.

Pregnancy and maternity
(include people who are pregnant, expecting a baby, up to 26 weeks post-natal or are breastfeeding)

Because pregnancy and maternity are temporary in nature it is complicated to estimate the impact of the guidance on individuals with these characteristics.

Registrants

Pregnancy and maternity may be considered, in some cases, as personal circumstances that are relevant to mitigation.

When considering a Conditions of Practice order, the committee must consider whether the proposed conditions will be workable. Maternity will be particularly important if the committee intends to impose conditions based on workplace supervision, training or further learning. These may be harder to fulfil if the registrant is not working at that time due to maternity (or paternity or adoption) leave.

The committee must also give reasons for the duration of any sanction, and pregnancy and maternity would likely be a factor in that decision making.

The guidance contains a provision to request a review hearing, which may be relevant if the chiropractor becomes pregnant after a sanction is imposed (and therefore being unable to meet the conditions of that sanction).

Patients and the public

While not specifically addressed beyond reference to maternity as a protected characteristic, the guidance contains several features that are relevant to the protection of people who are pregnant or have recently had a child. In particular, it strengthens the approach to discrimination, harassment and victimisation relating to protected characteristics, including pregnancy and maternity; emphasises the seriousness of sexual misconduct; treats abuse of vulnerability and abuse of trust as aggravating factors; and supports sanctions that maintain public confidence and protect patients from harm.

Race
(include nationality, citizenship, ethnic or national origins)

Registrants

The EDI Thematic Review of PCC cases found that there was no significant disparity in outcomes based on ethnicity, although the robustness of this finding was limited by the small sample sizes.

The guidance contains several features intended to support fair treatment of registrants and other participants from different racial, ethnic and cultural backgrounds. It recognises that the demonstration of insight, remorse and remediation may be influenced by cultural understanding, communication style and the use of a second language. The guidance reminds committees that cross-cultural communication differences can affect both the interpretation and expression of evidence and that awareness of these issues is important when assessing insight, remediation and credibility. The guidance expects the committee to test and corroborate evidence rather than rely only on the fact that evidence exists.

More broadly, the guidance reinforces the need for decisions to be fair, evidence-based and free from bias, and encourages committees to consider relevant contextual factors when evaluating evidence and submissions.

Patients and the public

The guidance strengthens the approach to discrimination, harassment and victimisation relating to protected characteristics, including race, ethnicity, nationality and national origins. By directing committees to recognise the harm caused by discriminatory conduct not only to individual complainants but also to public confidence the guidance addresses the impact of racism on the willingness of affected communities to access care. It further treats abuse of vulnerability, victimisation and conduct motivated by prejudice as serious matters requiring an appropriate regulatory response. It specifically references hate-motivated conduct (while it may fall short of the criminal definition of unlawful discrimination) as being of serious concern and directs the committee to consider definitions of antisemitism and racism.

Religion or belief
(include religious and philosophical beliefs, including lack of belief)

Registrants

The EDI Thematic Review of PCC cases found that there was no significant disparity in outcomes based on religion or belief, although the robustness of this finding was limited by the small sample sizes.

The guidance contains several features intended to support fair treatment of registrants and other participants regardless of their religion or belief. It reinforces the need for decisions to be fair, evidence-based and free from bias, and encourages committees to take proper account of context and protected characteristics when evaluating evidence and submissions. The guidance also recognises that the communication of insight, remorse and remediation may be influenced by personal and cultural factors and reminds committees to assess evidence carefully, test and corroborate significant evidence where appropriate, and avoid drawing adverse conclusions solely from an absence of evidence. These principles help support equitable decision-making for registrants from a range of religious and philosophical backgrounds.

Patients and the public

The guidance contains several features that are relevant to the protection of patients, colleagues and members of the public with different religions or beliefs. It strengthens the approach to discrimination, harassment and victimisation relating to protected characteristics, including religion or belief, and directs committees to recognise the harm caused by discriminatory conduct. The guidance further identifies abuse of vulnerability, victimisation and conduct motivated by prejudice as serious matters that may aggravate the seriousness of misconduct. The guidance specifically references hate-motivated conduct (while it may fall short of the criminal definition of unlawful discrimination) as being of serious concern and directs the committee to consider definitions of antisemitism and anti-muslim hostility.

Sex
(Male and female)

Registrants

Although not statistically significant, the 2024 EDI Thematic Review of 55 PCC cases (39 against male registrants and 16 against female registrants) found cases against male chiropractors were more likely to have a finding of UPC (49% - 19 cases) than cases against women (38% - 6 cases).

Of the cases where UPC was found, female chiropractors were more likely to receive a suspension (13% vs 5%) when UPC was found. Admonishments and removals are comparable rates between genders. Overall, while male chiropractors face a higher rate of UPC findings, female chiropractors appeared to receive more severe sanctions (suspensions and conditions of practice) when UPC is found. However, the sample size for female

chiropractors is too small for a statistically robust conclusion (each case represents a larger number of percentage points).

The guidance contains several features intended to support fair treatment of registrants and other participants regardless of sex or gender. It recognises that the communication and demonstration of insight, remorse and remediation may be influenced by personal circumstances and gender-related factors, and reminds committees to assess evidence in its proper context.

As previously identified (maternity and pregnancy), caring responsibilities may disproportionally impact female registrants' capacity to complete workplace supervision or training or learning as part of a conditions of practice order, and this should be reflected when considering the registrants ability to comply with a sanction.

Patients and the public

The guidance contains several features that are relevant to the protection of patients, colleagues and members of the public regardless of sex or gender. It strengthens the approach to discrimination, harassment and victimisation, and emphasises the seriousness of sexual misconduct, abuse of trust and exploitation of vulnerability.

The guidance directs committees to recognise the impact that such conduct may have on those affected and on public confidence in the profession, and supports sanctions that are proportionate to the seriousness of the behaviour. In doing so, it helps protect individuals from harm and promotes confidence that concerns involving sex-based discrimination, harassment or sexual misconduct will be treated appropriately and consistently.

Sexual orientation
(include heterosexual, lesbian, gay, bi-sexual, queer and other orientations)

Registrants

The guidance reinforces the need for decisions to be fair, evidence-based and free from bias, and requires committees to consider relevant contextual factors when evaluating evidence and submissions. These principles help support equitable decision-making for registrants of all sexual orientations and reduce the risk that assumptions, stereotypes or prejudice influence the assessment of credibility, insight or remediation. Based on our review, we have not identified any aspects of the guidance that would disadvantage registrants because of their sexual orientation.

Patients and the public

Research from the TUC in 2019 suggests that lesbian, gay and bisexual people are disproportionately targeted by inappropriate sexual behaviour in the workplace.

The guidance strengthens and widens the seriousness of sexual misconduct as an aggravating factor in FTP cases and guides that the sanction be of appropriate gravity. It specifically identifies that sexual misconduct does not need to be sexually motivated and

highlights sexual misconduct can be used to threaten, intimidate, offend, undermine, humiliate or coerce a person or group.

More generally the guidance directs committees to recognise the harm caused by discriminatory or prejudicial conduct, both to those directly affected and to public confidence in the profession, and supports sanctions that are proportionate to the seriousness of the behaviour. In doing so, it helps promote confidence that concerns involving homophobic, biphobic or other discriminatory conduct based on sexual orientation will be treated appropriately and consistently.

Are there any implications in relation to each/any of the different forms of discrimination defined by the Equality Act?

We anticipate that the guidance will have not have any detrimental impact on people with protected characteristics, and that the safety and professionalism of the chiropractic profession will be positively impacted by the guidance.

Intersectionality

While this assessment considers each protected characteristic separately, we recognise that individuals may experience multiple and overlapping characteristics and that these intersections can influence how they experience the fitness to practise process. For example, the experiences of a disabled registrant whose first language is not English may differ from those of a registrant who shares only one of those characteristics. Committees are expected to remain alert to the potential for cumulative disadvantage and ensure that relevant contextual factors are considered when assessing evidence, insight, remediation and compliance with sanctions.

Step 5 – Analysis of impact on Welsh Language and opportunities to use Welsh

Welsh Language speakers – understanding the impact In line with the GCC's duties under standard 42 of Welsh Language Standards consider the effect that the policy would have on opportunities for persons to use the Welsh language and to treat the Welsh language no less favourably than the English language.
The guidance references the policies that are already in place to ensure that registrants, patients and other participants can engage with the Fitness to Practice process through the Welsh Language. It highlights that the committee should not draw adverse conclusions from the use of Welsh, or treat the Welsh language otherwise less favourably than English.The guidance also recognises the importance of cultural and linguistic context when assessing evidence, insight, remorse and remediation, helping to ensure that Welsh-speaking participants are not disadvantaged during proceedings. Together, these provisions support a fair, accessible and proportionate fitness to practise process for Welsh speakers.
Welsh Language speakers – creating positive impacts In line with the GCC's duties under standard 43 of the Welsh Language Standards consider how the policy could be formulated so that the decision would have positive impacts on opportunities for persons to use the Welsh language and to treat the Welsh language no less favourably than the English language.
We do not believe that there are any further opportunities within the guidance on sanctions to increase positive impacts on opportunities for persons to use the Welsh language and to treat the Welsh language no less favourably than the English language. We believe the wider policies in place to meet the GCC's Welsh Language Standards will meet this requirement.
Welsh Language speakers – decreased adverse impacts In line with the GCC's duties under standard 44 of the Welsh Language Standards consider how the policy could be formulated so that the decision would have decreased adverse impacts on opportunities for persons to use the Welsh language and to treat the Welsh language no less favourably than the English language.
We do not believe that there are any further opportunities within the guidance on sanctions to decrease adverse impacts on opportunities for persons to use the Welsh language and to treat the Welsh language no less favourably than the English language. We believe the wider policies in place to meet the GCC's Welsh Language Standards will meet this requirement.

Step 6 – Other identified groups

Socio-economic group and income
Registrants Work by other health regulators has established that a key determinants in FTP outcomes, and subsequent sanctions, is whether a registrant is legally represented. We acknowledge that affordability of representation may be exacerbated for registrants from a lower socio-economic background or those on a lower income – this means that they could be disproportionately impacted as a result of this lack of access. This effect may be further exacerbated by intersections with other factors. In response, the guidance includes a section specifically addressing proceedings where a chiropractor is not legally represented – highlighting the assistance that should be provided and that the committee should not draw adverse conclusions from a lack of legal representation. There may be costs or financial losses incurred by chiropractors who are subject to any form of sanction. This increases with the seriousness of the sanction. The guidance acknowledges that suspension or removal from the register will have a punitive effect, in that it prevents a chiropractor from practising as a registered chiropractor. However, if the committee determines that a suspension is the proportionate sanction to fulfil the statutory over-arching objective, including maintaining public confidence in the profession, then it must impose that sanction. **Patients and the Public** The guidance treats abuse of trust, exploitation of vulnerability and victimisation as serious matters, helping to protect patients who may be less able to challenge poor treatment, seek alternative care or absorb financial losses arising from inappropriate conduct – particularly if caused by dishonesty or lack if integrity by a chiropractor. The guidance supports robust regulatory action in cases of dishonesty or lack of integrity, where financial gain (at the expense of a patient) is a concern and emphasises the importance of maintaining public confidence and protecting patients from harm.

Four countries diversity How does the policy interact with the legal and cultural frameworks of the countries in which the GCC has a legal framework?
We have not identified any issues where the expectations within the guidance are in conflict with the legal or cultural frameworks of the countries in which we operate. The aspects of this guidance relating to protected characteristics highlight as a legal framework the Equality Act (2010) in England, Scotland and Wales, and Section 75 of the Northern Ireland Act (1998) and others.

Step 7 – Summary of analysis

The revised guidance is expected to have a positive impact on equality, diversity and inclusion. It strengthens the approach to discrimination, harassment, victimisation, abuse of trust, exploitation of vulnerability and sexual misconduct over the previous edition, helping to protect patients, the public and the wider reputation of the profession.

The guidance also supports fairness for registrants and other participants in the fitness to practise process by emphasising objective, evidence-based decision-making and the need to consider relevant context and individual circumstances. It includes safeguards intended to reduce the risk of bias and to ensure that factors such as disability, health conditions, language, cultural background, pregnancy, maternity and caring responsibilities are appropriately considered where relevant.

No aspects of the guidance have been identified that are likely to result in unlawful discrimination or disproportionate adverse impacts on people with protected characteristics. The guidance is compatible with the GCC's Welsh Language Standards and supports a fair and accessible process for Welsh-speaking participants.

Overall, the guidance is expected to promote fair, consistent and proportionate decision-making while strengthening protections against discriminatory and harmful conduct. The impact of the guidance will be monitored following implementation to identify any unintended consequences and inform future reviews.

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General Chiropractic Council

For noting and approval
(as applicable)

Report from the Chair of the Education Committee

Purpose

The purpose of this paper is for Council to receive an update from the Chair of the Education Committee, following its meeting on 08 July 2026. Council is also asked to consider the recommendations from the Committee regarding the Stage 5 recognition outcome of the Scotland College of Chiropractic degree programme.

Updates from Education providers and programmes

1. The Committee noted that Teesside University had been informed that the GCC would commence enhanced monitoring of its chiropractic programme from Autumn 2026, until the final cohort of students had graduated. Members were advised that this would include annual visits to the institution to meet with staff, students and stakeholders.

2. The Committee was informed that a substantive change notification had been received from Health Sciences University (HSU), outlining recent changes to its senior leadership team, including the appointment of a new Head of School and revised clinical leadership arrangements. The Committee noted that measures had been put in place to ensure the continued effective operation of the clinic and delivery of clinical education.

3. The Committee noted that Coventry University had submitted evidence in relation to two outstanding conditions from its approval report. Members were advised that the Education Visitor panel had confirmed one condition had been met and that the remaining condition, relating to interprofessional learning, was partially met. Progress against the associated action plan would continue to be monitored through the annual monitoring process.

4. The Committee was informed that Plymouth Marjon University has postponed submission of its Stage 3 documentation until November 2026. Members noted that the delay reflected competing institutional priorities and that the University intends to complete the submission over the summer for review later in the year.

Review of the policy for Continuing Professional Development

5. The Committee noted that the project was progressing as planned, with Workstream one complete and the review now moving into the next phase of exploring potential future CPD models and approaches. Members were advised that feedback from the Steering Group and engagement with the professional associations and the Royal College of Chiropractors would inform the development of future options.

6. The Committee noted that a communications and engagement programme had commenced, including the launch of *The CPD Conversation* on the GCC website to provide information and updates on the review and opportunities for stakeholder engagement.

7. The Committee was informed that the review was exploring a more outcomes-focused approach to CPD, while ensuring that any future framework remained proportionate, supported professional autonomy and maintained public confidence. Members also noted that legal advice would be sought to clarify the scope for change within the existing legislative framework.

8. The Committee noted that a more substantive report, including potential future options, would be presented at the November Education Committee meeting.

Scotland College of Chiropractic (SCC) - Stage 5 Recognition outcome for a new programme

9. The Committee received the report by the Education Visitor Approval Panel following its visit to SCC on 8 and 9 June 2026.

10. The Committee agreed to recommend to Council that the proposed chiropractic degree programme at SCC be approved with conditions, as set out in the Approval Panel's report. Details of the approval visit, the Education Committee considerations and the Approval report can be found in the **Annex** to this paper**.**

Committee Work Plan

11. The Committee noted the work plan for the year July 2026 - July 2027.

12. The next meeting of Committee would be on 19 November 2026.

Catherine Kelly

Chair of the Education Committee

General Chiropractic Council

For approval

Report from the Chair of the Education Committee - Stage 5: Recognition of a New Programme

Agenda item 8A - Annex

Purpose

The purpose of this paper is to present Council with the report by the Approval Panel following its Stage 4 approval visit to the Scotland College of Chiropractic, undertaken in accordance with the GCC Quality Assurance Handbook.

Recommendation

The Council is asked to agree the recommendation from the Education Committee that the proposed chiropractic degree programme at the Scotland College of Chiropractic (SCC) be approved with conditions as set out in the Approval Panel's report. Subject to that decision, the Council's decision to recognise the new programme will then be progressed to the Privy Council for its approval.

Background

1. At its meeting on April 29 2026, the Education Committee agreed that the full programme submission from SCC met the Stage 3 requirements of the recognition process, allowing the application to proceed to Stage 4 – the Approval Panel visit.

2. The GCC appointed an Education Visitor Approval Panel consisting of two lay members and two registrant members with significant expertise and experience in higher education.

3. The Approval Panel visit took place on 8 and 9 June 2026. During the visit, the Panel toured facilities and met with staff, students, patients and placement providers.

4. A visit programme, highlighting indicative areas to be covered during the visit and required attendees was agreed in advance.

5. Prior to the visit, SCC provided the GCC with their latest financial information together with a supporting financial narrative.

6. The Approval Panel's report, following the visit, was considered by the Education Committee at its meeting on 8 July 2026.

Approval Visit

7. The Panel held ten meetings with senior managers and representatives of Buckinghamshire New University (BNU), the programme's validating university, programme staff, clinical educators, student support staff, students from across the programme, patients and placement providers.

8. The Panel found evidence of significant progress since earlier engagement with SCC and was particularly impressed by the substantial investment made in the campus, teaching accommodation and clinical facilities. The quality of the facilities, learning resources and clinical environment led the Panel to make a specific commendation.

9. During its meeting with senior managers and representatives of BNU, the Panel explored the financial sustainability of the College. The Panel was assured that financial performance, student recruitment and organisational risk are subject to regular monitoring and oversight. Senior managers demonstrated a realistic understanding of recruitment patterns, workforce planning and future growth requirements, together with awareness of the associated risks and mitigating actions. Recruitment had remained stable despite the absence of programme approval, retention rates were strong, and the College presented forecasts indicating sustainable student recruitment over the next four years.

10. The Panel sought assurance regarding student protection arrangements if recruitment became unsustainable or the College be unable to continue operating. It was confirmed that formal 'teach-out' and transfer arrangements were in place through BNU, which would work with the College to ensure continuity of study for affected students. The Panel was satisfied that appropriate contingency arrangements existed to protect students and concluded that the College had appropriate plans in place to support the ongoing sustainability of the programme.

11. Through its meetings with staff, students, patients and placement providers, the Panel was able to explore in detail those areas identified for further scrutiny during the analysis undertaken at Stage 3. The visit provided assurance regarding safeguarding, support offered to students, patient-centred care, clinical supervision, placement learning, assessment processes, clinical governance and the integration of evidence-based practice throughout the curriculum. Areas that had required further exploration at Stage 3 were tested extensively through a combination of stakeholder meetings, documentary evidence and direct observation of facilities and resources.

12. The Panel triangulated evidence across the different meetings and stakeholder groups, placing weight on the direct experience of students and patients. The Panel noted that there had been improvements in the culture and ethos of the programme, with a more collegiate and team-based approach. It had also seen stronger engagement from BNU, including regular contact and clearer involvement around quality-assurance. It was noted that the input of an external critical friend and the external examiner had also contributed positively to programme development.

13. Having considered all the evidence available through the programme submission, supporting documentation and approval visit, the Panel concluded that the programme met all GCC Education Standards.

14. During the final meeting with the College Senior Management Team, the Panel Chair fed back that its indicative recommendation to the Education Committee was to recommend the approval of the programme, with conditions, with approval taking effect from the commencement of the new Year 1 intake in September 2026. It was emphasised by the Panel Chair that students who commenced the programme prior to September 2026 would be subject to the requirements of Condition 5, as outlined in paragraph 19 below.

15. While the Panel agreed that all Education Standards were met, it recommended recognition of the programme with six conditions which are set out in full in the Approval Panel's report at the **Appendix**. The Panel Chair stated that conditions were intended to ensure that governance arrangements, systems in place to support students, patient and public involvement, evidence-based practice and quality assurance processes developed in line with the expansion of the Institution.

16. Following the meeting, the Panel issued a report to SCC on 19 June 2026 for comment, and response by SCC to the approval report was received on 24 June 2026 and shared with the Panel.

Considerations of the Education Committee

17. At the Education Committee on 8 July 2026, the Approval Panel Chair presented the findings from the desk top analysis and Approval Panel visit to SCC. The Panel Chair informed the Committee that the Panel was assured that the provider had demonstrated sufficient evidence that the Education Standards were met, recommending that the proposed chiropractic programme be recognised with conditions.

18. The Committee carefully scrutinised the Approval Panel's findings and recommendation. Members questioned the evidence supporting the recommendation, the improvements made by the College since the earlier stages of the recognition process, the proposed conditions, financial sustainability, the assessment strategy, governance arrangements and the arrangements for monitoring the programme following approval.

19. The Committee considered the implications of Condition 5 as to the registration of students in extant cohorts upon graduation. The Panel Chair confirmed that Condition 5 applied solely to that cohort and that those students could not proceed directly to registration unless the GCC was satisfied that any identified gaps against the Education Standards had been addressed, and that those students had demonstrated that they met the requirements of current Education Standards. Further, the Panel Chair stated that approval of the programme (that is, for the September 2026 intake and subsequent cohorts) was independent of Condition 5.

20. The Committee considered the report and information provided by the Panel Chair and agreed the Approval Panel recommendation that the proposed chiropractic degree programme at Scotland College of Chiropractic be recognised with conditions as set out in the Approval Panel's report.

Next steps

21. If the Council accepts the recommendation for approval of the chiropractic degree programme at Scotland College of Chiropractic, a recommendation will be made to the Privy Council seeking formal recognition of the programme. The Privy Council approval process can take several months and the programme will not be formally recognised until an Order in Council has been made.

Elizabeth Austin

Education and Standards Officer

Appendix

Education Visitors' Report (Approval of a Programme)

Name of Educational Institution	The Scotland College of Chiropractic
Programme Name	Master of Chiropractic (MChiro)
Start Date of Programme	September 2026
Date of Visit	8 & 9 June 2026

Introduction

The Scotland College of Chiropractic (SCC) made a full Stage 3 programme submission to the General Chiropractic Council (GCC) in March 2026 for consideration by the Education Committee at its April 2026 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 27 May 2026, 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 SCC's March submission.

Ahead of the Stage 4 visit, the Panel shared an agenda with the College, which included a tour the campus and meetings with senior management, teaching and support staff, placement providers, patients and students enrolled on the current programme.

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 27 May 2026, 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 staff from both the College and Buckinghamshire New University and other stakeholders including students, placement providers and patients.

Monday 8 June 2026

Tour of facilities

The Panel toured both the teaching and clinical facilities, accompanied by the Principal and Director of Business Development.

The clinic is situated on the ground floor of the College and occupies a prominent position within the local high street. The panel observed a spacious and welcoming reception area and heard that students are actively involved in front-of-house duties as part of their preparation for professional practice. Students receive training in reception and administrative processes and, during clinical shifts, undertake responsibilities associated with patient bookings, communication and clinic operations. The panel heard that arrangements are in place to ensure continuity of patient communication, including a voicemail system that directs messages to the front desk email account when the clinic is unattended.

The panel observed a well-organised clinical environment comprising nine treatment rooms, dedicated radiography facilities, a rehabilitation area, clinic tutor accommodation and supporting utility spaces. Clinical activity is structured to provide students with experience across a range of roles, including patient management and radiography in addition to reception duties. The panel heard that each clinic session begins with a team briefing and that operational procedures, patient feedback mechanisms and complaints processes are clearly embedded within clinic activity. Students also complete structured opening and closing procedures at the beginning and end of each clinical shift.

The panel was particularly impressed by the quality of the clinical facilities and the thought that had been given to creating an authentic practice environment. Students appeared to have ready access to clinical tutors throughout clinic sessions, supporting both patient safety and student learning. The panel also viewed the rehabilitation area and recognised its value in supporting patient management and rehabilitation activities. Whilst the panel questioned whether a larger space may ultimately be required as clinic activity expands, it acknowledged that the suitability of the current arrangements could be evaluated further once the clinic is operating at full capacity and serving a larger public patient population.

The panel also toured the wider campus facilities and observed significant investment in the learning environment. New and upgraded student facilities included social learning spaces, kitchens, showers, study areas and dedicated spaces for student activities. The panel viewed tutor offices, module leader accommodation, library facilities and a range of individual and group study spaces. Teaching accommodation included large practical teaching rooms and flexible classroom spaces capable of being adapted to support a variety of learning activities.

The panel was impressed by the significant investment that had been made in developing the campus and clinical facilities and considered that the progress achieved since earlier engagement with the College should be commended.

Meeting 1: Senior Management Team

Attendees: Dr Ross McDonald (Principal), **Leigh Dilks** (Director of Business Development), **Dr Elisabeth Cook** (Director of Quality Assurance) and **Dr Ayoub Zoura** (BNU Director of Collaborative Relationships)

Institution strategy and sustainability: The panel explored the strategic vision underpinning the College and to seek assurance regarding the sustainability of the institution and programme. Senior managers described the establishment of the College in response to a recognised need for chiropractic education within Scotland and articulated ambitions to develop a sustainable educational institution supporting workforce development, research activity, continuing professional development and future postgraduate provision.

The panel heard that research development remains an important strategic ambition, with plans to strengthen practice-based research and collaborative activity with universities and healthcare partners.

The panel explored the financial arrangements supporting the programme and heard that financial performance, recruitment and organisational risk are subject to regular monitoring. Senior managers reported that financial modelling has evolved over time and demonstrated an increasingly realistic understanding of recruitment patterns and operational requirements.

Student recruitment remains a key institutional priority. The panel heard that recruitment has remained stable despite the absence of programme approval and that student retention rates have been strong. Senior managers reported a 100% retention rate for students in the current Years one and two. Two students from the 2023-24 cohort had withdrawn from the programme: one during Year one and one during Year two. The College continues to recruit for the current intake and expressed confidence in achieving a cohort of approximately 12 students, with forecasts suggesting annual intakes of between 12 and 16 students over the next three years. The panel also heard that some applicants had elected to defer entry to a future intake and that opportunities to expand recruitment further, including international student recruitment, were being explored in discussion with the QAA and Home Office. Senior managers also described aspirations to pursue accreditation through the European Council on Chiropractic Education (ECCE) in the future. Whilst acknowledging that future growth will be necessary to support expansion plans, the team demonstrated awareness of the associated risks and mitigating actions.

The panel sought assurance regarding arrangements that would be implemented should recruitment become unsustainable or if the College was unable to continue operating. Senior managers explained that students would be protected through teach-out arrangements or supported transfer opportunities. The panel heard from the Director of Collaborative Relationships at Buckinghamshire New University (BNU), who confirmed that BNU maintains formal exit and teach-out procedures and would work directly with the College and students to ensure continuity of study for any students who may be affected. The panel considered these arrangements to provide important assurance regarding student protection and continuity of education.

Staffing: The panel explored staffing arrangements and future workforce planning. Senior managers acknowledged that additional recruitment will be required as further cohorts progress into the clinical phases of the programme and described ongoing efforts to

strengthen staffing capacity, particularly within the clinical teaching environment as the students progress into year four of the programme.

The panel heard that recruitment of clinic tutors and senior clinical staff has presented some challenges, reflecting wider workforce pressures within the profession. However, the institution demonstrated awareness of future staffing requirements and had begun planning for additional appointments to support expanding clinical activity.

The panel heard that the College is committed to supporting staff professional development, with mandatory training in areas such as equality, diversity and inclusion and safeguarding already established. In line with BNU requirements, academic staff are also expected to work towards an appropriate teaching qualification, which will commence in September 2026.

Discussion also focused on succession planning and organisational resilience. The panel noted that a significant number of leadership, operational and academic responsibilities currently sit with the Principal. Whilst plans are in place to redistribute responsibilities as the College grows, the panel considered that reducing reliance on key individuals and strengthening organisational resilience will be important as programme delivery becomes increasingly complex.

Stakeholder engagement: The panel sought clarification regarding the involvement of patients and carers in programme development and governance. Senior managers described the recent establishment of a patient and carer group intended to provide feedback on educational and clinical aspects of the programme.

The institution demonstrated a clear commitment to strengthening patient and public involvement over time, particularly as the clinic expands and begins serving a larger public patient population. The panel noted positive intentions regarding future patient involvement in programme review, quality assurance processes and governance activities. However, patient and public involvement remains at an early stage of development and arrangements relating to recruitment, support, training and meaningful engagement have yet to be fully realised. The panel therefore considered that a more strategic and comprehensive approach to patient and public involvement would strengthen programme development and quality enhancement activities.

Interprofessional learning: The panel explored current and planned interprofessional learning opportunities. Senior managers acknowledged that creating meaningful interprofessional learning experiences had been challenging but described existing collaborative activities with physiotherapy and sports science students from BNU together with plans for further development.

The institution demonstrated a clear understanding of the importance of collaborative practice and described a range of planned developments intended to expose students to wider healthcare perspectives. The panel considered the commitment to developing interprofessional learning to be positive and recognised that approval would likely facilitate the expansion of collaborative opportunities.

Evidence based teaching: The panel explored how evidence based practice is embedded throughout the programme. Staff described a curriculum that progressively develops students' understanding of evidence sourcing and its appraisal, research methodology and the application of evidence within clinical decision-making. The panel also heard examples of how evidence is incorporated within activities aimed at developing

clinical reasoning skills, case discussions, patient management planning and decision making.

The panel welcomed the programme's commitment to evidence-based practice and was assured that this is embedded throughout the curriculum. However, it considered that further articulation of how evidence informs clinical decision-making would strengthen the programme's approach.

Meeting 2: Staff Responsible for Self-Directed and Virtual Learning

Attendees: Lucie Koutna (Programme Administrator) and **Dr Ross McDonald**. **Julia Veness** (BNU Digital Learning Team) attended online.

Virtual learning environment (VLE): Staff described the recent transition to Blackboard Ultra and the adoption of standardised module templates designed to improve consistency, navigation and student engagement. The panel heard that the VLE is used to support active learning through interactive activities, discussion opportunities and self-directed learning tasks. Recorded content and digital resources are routinely made available to students and can be accessed remotely at any time.

The panel was reassured that a well-developed digital learning environment was in place and that careful consideration had been given to consistency, accessibility and student engagement across the programme, supported through the partnership with BNU. Students had access to a range of self-directed learning resources to support effective use of the systems, together with access to technical support and helpdesk facilities where required.

Accessibility: The panel explored the arrangements in place to support accessibility and inclusive learning. Staff described the use of accessibility tools embedded within the VLE and explained how learning materials are reviewed and adapted to improve accessibility for students with differing needs.

The discussion provided assurance that accessibility considerations are embedded within digital learning design and that appropriate support mechanisms are available to both staff and students.

Assessment and feedback: The panel explored the use of digital systems to support assessment and feedback. Staff described electronic processes for coursework submission, marking and feedback, together with the provision of formative and summative feedback through the VLE. Students are also supported through guidance on academic writing, assessment preparation and the use of similarity checking tools.

The panel heard that students have access to a range of learning resources through both SCC and BNU, including electronic journals and specialist subject resources. Processes are in place to identify and acquire additional resources where required.

The panel found evidence that digital systems are integrated effectively within the student learning experience and that appropriate resources are available to support programme delivery and student achievement.

Meeting 3: Staff Responsible for Student Support Services

Attendees: Dr Bettina Tornatora (Programme Leader), **Dr Alanna Jarrott** (personal tutor), **Dr Kelly McLaughlin** (personal tutor), **Leigh Dilks** and **Dr Elisabeth Cook** to explore the support available to students throughout the programme.

Student support: Staff described a range of support mechanisms combining internal pastoral support with specialist external services. Students requiring assessment for additional learning needs are referred to appropriate providers and, where necessary, individual learning support plans and reasonable adjustments are implemented and reviewed regularly. The panel heard that student welfare is discussed routinely and that concerns are identified and addressed proactively.

The panel found evidence of a supportive culture in which staff demonstrated a clear awareness of the importance of student wellbeing and early intervention. However, whilst examples of effective support were evident throughout the discussion, responsibility for student support appeared to be distributed across a range of individuals, processes and external services. The panel considered that a more comprehensive and clearly articulated student support framework would provide greater clarity and signposting regarding available support, escalation pathways and responsibilities for students experiencing academic, personal or wellbeing-related difficulties.

The panel explored arrangements for supporting students experiencing financial hardship and heard that a dedicated hardship fund is available to provide short-term financial assistance where required. Evidence was provided that the fund had been used successfully to support students during periods of financial difficulty.

Personal tutors: Students are allocated personal tutors on enrolment and are expected to meet regularly throughout the academic year. Staff described arrangements for monitoring student engagement and managing tutor allocations, including processes to address potential conflicts of interest where necessary.

The panel welcomed the commitment demonstrated by staff towards supporting individual students and found evidence of a responsive and student-centred culture. However, the panel considered that the various support mechanisms described during the meeting would benefit from being brought together within a single overarching framework to ensure consistency, transparency and accessibility for students

Student voice: The panel explored the mechanisms used to gather and respond to student feedback. Staff described a range of formal and informal feedback channels, including student representatives, programme committees and module evaluations. The panel heard that student representatives contribute actively to governance processes and that feedback is routinely analysed and communicated back to students. The panel found evidence that student feedback is valued and used constructively to support programme enhancement.

Meeting 4: Students from years one and two of the programme

Attendees: Seven students from years one and two of the programme.

The Panel explored the students' experiences of studying at the Scotland College of Chiropractic.

Learning environment: Students spoke positively about the learning environment and consistently described the College as supportive, approachable and responsive.

Students highlighted the benefits of studying within small cohorts and reported that staff were accessible and responsive to both academic and personal concerns. The panel heard that students valued the strong relationships they had developed with academic and support staff and regarded the support available as a significant strength of the programme.

VLE: Students reported positive experiences of the VLE and described the systems supporting digital learning as reliable and easy to navigate. The panel heard that induction arrangements had prepared students well for using the available systems and that communication regarding updates and changes was effective.

Students confirmed that they were generally able to access the learning resources required to support their studies and were aware of mechanisms for requesting additional materials where necessary. Resources identified within reading lists were available and students reported being able to access wider sources to support both independent and collaborative learning when required.

Placements: The panel explored students' experiences of observational placements and heard consistently positive feedback regarding these opportunities. Students described placements as valuable in helping them connect classroom learning with professional practice and develop a greater understanding of patient-centred care.

Students reported that placements were well organised and provided opportunities to observe patient interactions, clinical decision-making and professional communication in authentic practice settings.

Assessment and feedback: Students consistently reported feeling well prepared for assessments and highlighted the availability of revision sessions, formative activities and assessment guidance. Feedback was described as timely, constructive and supportive of future learning.

Students considered the workload demanding but manageable and reported that they were generally able to balance academic commitments with employment and personal responsibilities.

Throughout the discussion, students demonstrated enthusiasm for the programme and confidence in the support provided by the institution. The panel found student feedback to be overwhelmingly positive and noted a strong sense of engagement with both the programme and the wider development of the College.

Meeting 5: Programme Team responsible for teaching years one and two of the programme

Attendees: Dr Bettina Tornatora, **Dr Rebecca Vickery** and **Dr Ross McDonald. Dr Luisa Wakeling, Dr Rob Sandford, Dr Mark Spriggs** and **Dr Asha Venkatesh** attended online.

Underlying philosophy underpinning the chiropractic programme: Staff described a curriculum designed to produce practice-ready chiropractors capable of delivering safe, patient-centred and evidence-based care in accordance with the GCC Education Standards. The staff explained that the programme adopts a developmental approach in which students revisit key concepts with increasing complexity and clinical relevance, progressively integrating scientific knowledge, clinical reasoning, professional behaviours and patient management skills.

Evidence based practice: Staff described an approach in which research literacy, critical appraisal and scientific enquiry are introduced early and developed progressively through teaching, assessment, case discussions and reflective activities. Students are encouraged to engage with contemporary research literature, clinical guidance and emerging evidence and to apply these within clinical decision-making.

The panel welcomed the programme team's commitment to evidence-based practice and recognised that research literacy and critical appraisal skills are introduced early and developed throughout the programme. The panel was assured that evidence-based practice is embedded throughout the curriculum in years one and two and reflected within teaching, learning and assessment. However, it considered that continued review of the evidence underpinning aspects of clinical management, including ongoing care and cessation of care, would further strengthen this aspect of the programme and support its ongoing alignment with contemporary evidence-based practice.

Patient-centred care: The panel was informed that patient centred care is embedded throughout the programme and that students are encouraged to work in partnership with patients, recognising individual goals, preferences, values and circumstances when developing management plans. Communication skills, consent, shared decision-making and referral processes are integrated throughout teaching and assessment.

The panel welcomed the emphasis placed on consent, patient autonomy and shared decision-making and noted discussion relating to referral, cessation of care and situations in which patients may choose not to proceed with chiropractic management. Whilst assured that patient-centred care is embedded throughout the programme, the panel considered that further opportunities for students to explore how the values and preferences of patients, together with contemporary evidence, inform decisions relating to ongoing management and discharge would strengthen this aspect of the programme.

Clinical reasoning and professional identity: Staff described a curriculum that progressively develops students' ability to synthesise information, evaluate evidence and make appropriate clinical decisions while recognising the limits of their competence and the need for collaborative practice where appropriate.

Professional identity was described as encompassing ethical practice, accountability, reflective capability and ongoing professional development, rather than being defined solely by technical skills. The panel noted a strong commitment to developing reflective and professionally accountable practitioners. However, discussion suggested that

opportunities for students to develop and demonstrate leadership capabilities within wider healthcare settings could be strengthened further as the programme develops.

EDI: The panel explored how EDI is addressed within the curriculum and was encouraged by the breadth of examples provided and particularly welcomed the integration of EDI themes across multiple modules. The discussion demonstrated a clear commitment to preparing students to work effectively with diverse patient populations and to recognise the impact of wider social determinants on health and healthcare outcome

Assessment: Staff described an assessment strategy designed to evaluate knowledge, practical skills, clinical reasoning, professional behaviours and reflective capability through a range of authentic assessment methods aligned to programme outcomes and professional requirements.

The panel heard that assessment methods had evolved in response to feedback and ongoing curriculum review, with increasing emphasis placed on authenticity and integration. Feedback was described as an important component of student development and students are encouraged to use feedback to support ongoing improvement and professional growth.

The panel welcomed the programme team's focus on authentic assessment and the emphasis placed on evaluating students' ability to apply knowledge rather than simply recall information. The panel noted evidence that assessment design had evolved in response to previous feedback and found a clear rationale underpinning the choice of assessment methods.

Reflective practice: The panel explored how students are encouraged to develop reflective capability and prepare for lifelong learning. Staff described a developmental approach to reflection that progresses from structured reflective techniques towards increasingly critical and analytical reflection, supported through portfolios, case discussions, practical sessions and feedback activities.

The developmental approach to reflection was clearly articulated and demonstrated a commitment to supporting students' growth as reflective practitioners. The panel welcomed the programme team's intention to continue reviewing portfolio activities as future cohorts progress through the programme to ensure they remain effective in supporting reflective practice and professional development.

Digital technologies: The panel explored how students are prepared for contemporary practice and the increasing use of digital technologies within healthcare. Staff described plans for the integration of electronic records, digital documentation and technologies relevant to modern chiropractic practice, alongside teaching relating to information governance, confidentiality and professional responsibilities.

The panel welcomed the programme team's recognition of the growing importance of digital technologies within healthcare and heard examples of developments relating to electronic records, outcome measures and digital communication. The discussion provided assurance that students are being introduced to technologies relevant to contemporary practice. The panel welcomed the programme team's ongoing plans to further develop this area as the programme and clinical environment continue to mature.

Tuesday 9 June

Meeting 1: Programme team responsible for teaching years three and four of the programme

Attendees: Dr Rob Sandford, Dr Richard McWilliam, Katrina Lake and **Dr Ross McDonald. Dr Mark Spriggs and Dr Stephanie Adams** attended online.

Clinical portfolios and reflection: The panel explored how clinical portfolios support professional development and readiness for practice. Staff described a developmental approach in which students progress from observational learning towards increasingly active participation in patient assessment, clinical decision-making and patient management. Reflection is embedded throughout the portfolio process and is used to support self-awareness, professional judgement and lifelong learning.

The panel welcomed the emphasis placed on reflection and professional development throughout the programme. Staff demonstrated a clear understanding of the role of reflection in supporting professional judgement, clinical reasoning and lifelong learning. The panel was assured that reflective practice is embedded throughout the programme and welcomed the programme team's commitment to ongoing review of portfolio activities as future cohorts progress through the programme.

Safeguarding and Professional Responsibilities: The panel explored how safeguarding knowledge and professional responsibilities are developed across years three and four. Staff explained that safeguarding is embedded throughout both classroom and clinical learning and reinforced through case-based learning, assessment, simulation activities and clinical supervision. Examples were provided of how safeguarding principles are applied within educational and clinical settings. Students are expected to demonstrate an awareness of safeguarding issues, professional boundaries, consent and vulnerability when assessing patients and developing management plans.

The panel was reassured that safeguarding principles are embedded throughout the curriculum and that students are encouraged to consider safeguarding as part of routine clinical decision-making. The discussion demonstrated awareness of the challenges associated with professional boundaries, consent and vulnerability. The panel considered that ongoing review of safeguarding arrangements will be important as clinical activity expands and students assume greater responsibility for patient management. The panel also recommended consideration around students treating family members be undertaken.

Evidence-Based Practice, Clinical Decision-Making and Patient-Centred Care: The panel explored how students develop research literacy and apply evidence within clinical decision-making and patient management. Staff described an approach in which students are expected to engage with research evidence throughout their clinical education and justify clinical decisions through case discussions, presentations and reflective activities. Students are encouraged to integrate research evidence, clinical findings, professional judgement and patient preferences when developing individualised management plans.

The discussion highlighted how students are prepared to consider a range of management options, including rehabilitation, self-management, lifestyle advice, referral pathways and chiropractic intervention, whilst recognising situations in which alternative approaches or referral, either within or outside the profession, may be more appropriate. Examples were provided of how patient goals, preferences and circumstances are incorporated into clinical decision-making, together with consideration of review of care,

ongoing management and cessation of treatment. Discussion included the role of rehabilitation within both the curriculum and clinical environment as an important component of evidence-based patient management. The panel was reassured that students are encouraged to consider rehabilitation and self-management strategies, including approaches that patients can undertake independently as part of their ongoing care.

Whilst assured that patient centred care and evidence based practice is embedded throughout the programme, it considered that continued review of how evidence informs clinical management decisions, particularly in relation to ongoing care, review of care and cessation of treatment, would further support ongoing alignment with contemporary evidence-based practice.

Diagnostic Imaging and Clinical Application: The panel explored the teaching of diagnostic imaging and its application within clinical practice. Staff explained that imaging education progresses from foundational knowledge towards clinical interpretation, decision-making and patient management. Students are encouraged to critically evaluate the use of imaging, justify requests through clinical reasoning and consider how findings may influence patient management.

The panel welcomed the supervision and governance arrangements described by staff and was assured that imaging is incorporated appropriately within the curriculum. However, it considered that continued review of teaching, learning and assessment relating to imaging decisions and their role within patient management would support ongoing alignment with contemporary evidence-based practice.

Complexity, Co-Morbidity and Clinical Reasoning : The panel explored how students are prepared to manage complexity and co-morbidity within clinical practice. Staff described a curriculum that progressively introduces increasingly complex clinical presentations, encouraging students to apply differential diagnosis, evaluate uncertainty and justify clinical decisions within realistic patient scenarios. Students are taught to recognise red flags, understand referral pathways and appreciate the role of other healthcare professionals in patient care.

The panel welcomed the programme team's focus on complexity, uncertainty and clinical reasoning and heard examples demonstrating how these concepts are introduced progressively throughout the programme. Staff recognised that exposure to increasingly diverse patient populations would be important in further developing students' clinical reasoning and decision-making skills. Whilst the panel was assured that students are being prepared appropriately to manage complexity and uncertainty in practice, it considered that, as the clinic continues to expand, systematic monitoring of student exposure to the breadth, depth and complexity of clinical presentations will be important to ensure that all students have equitable opportunities to develop these capabilities.

Meeting 2: Patients and Service Users, Including Representatives from the Patient Group

Attendees: Three patients receiving care within the student clinic and the Patient and Carer Lead of the patient group.

The panel explored patients' experiences of the programme and sought assurance that patient-centred care is embedded within clinical delivery.

Patient experience: Patients spoke positively about their experiences and consistently described staff and student interns as approachable, professional and supportive. Patients reported receiving clear explanations regarding their conditions, treatment options and management plans and demonstrated an understanding of the goals of their care. The panel heard that patients felt comfortable asking questions, expressing preferences and participating in decisions regarding their treatment.

Patients appeared able to articulate the purpose of their care and demonstrated an understanding of their role in decision-making. The discussion provided assurance that patients are viewed as active participants in their care rather than passive recipients of treatment.

Patient group: The panel explored the role of the patient group and its contribution to programme and clinic development. The Patient and Carer Lead described a culture in which feedback is welcomed and used to inform service improvements. The panel heard examples of feedback relating to appointment systems, communication and the clinic environment, together with aspirations to expand patient involvement in quality assurance and programme review activities.

The panel welcomed the commitment demonstrated towards developing meaningful patient involvement and found evidence that the foundations of an effective patient voice structure are emerging. However, patient and public involvement remains at an early stage of development. Membership of the group is currently limited; governance arrangements continue to evolve and the role of patient representatives within wider programme activities is not yet fully established. The panel therefore considered that further development of recruitment processes, support mechanisms and opportunities for engagement would strengthen this aspect of the programme.

The panel heard evidence that patient feedback is actively sought and that concerns can be raised through both formal and informal channels.

The panel was encouraged by the positive experiences described by the patients and the discussion provided assurance that the College is developing mechanisms through which patient voices can contribute to future programme enhancement.

Meeting 3: Students from year three of the programme

Attendees: Four students from year three of the programme

The panel met to explore the students' experiences of clinical education and readiness for practice.

Preparedness for clinic: Students spoke positively about their preparation for clinic and reported that earlier learning experiences, including observational placements, had provided a strong foundation for supervised patient care. Students described feeling appropriately challenged whilst remaining well supported as they assumed increasing responsibility for patient management. Students were able to clearly articulate how earlier observational learning had contributed to their readiness for clinic and professional development.

Supervision: The panel explored supervision arrangements within the clinic. Students consistently reported that clinical tutors were accessible, supportive and actively involved in patient management. Students described opportunities for discussion and feedback

before, during and after patient consultations and demonstrated an understanding that expectations increase as competence and confidence develop.

There was further discussion regarding students' experience of diagnostic imaging. The panel was assured that academic teaching and opportunities to practise using dummy imaging equipment were well supported. Students reported variable opportunities to undertake imaging within the junior clinic, reflecting the differences in patient presentations and case mix. It was noted that imaging decisions and image interpretation were subject to supervision and review by clinical tutors. However, the panel considered that more explicit mechanisms for direct supervision, review and sign off of imaging activity could be strengthened.

Students also provided examples of referral decisions, imaging requests and interactions with other healthcare professionals, demonstrating awareness of patient safety, professional responsibilities and the limits of chiropractic practice.

The panel welcomed the positive feedback regarding clinical supervision and found evidence of a supportive learning culture. Students appeared comfortable seeking guidance when required and demonstrated a clear awareness of the limits of their competence. The discussion provided assurance that appropriate safeguards are in place whilst allowing students to progressively develop autonomy and professional judgement.

Patient centred care: Patient-Centred Care: The panel explored how students involve patients in decisions regarding their care. Students described patient-centred care as a fundamental component of clinical practice and demonstrated an understanding of shared decision-making principles. Students reflected on how concepts of patient-centred care are introduced early in the programme and revisited throughout their studies across teaching, case-centred learning and clinical observation. They also reported that patient goals, preferences and outcome measures are incorporated into management planning and ongoing review of care.

Students demonstrated an understanding of consent, patient autonomy and collaborative decision-making, providing assurance that these principles are being translated into clinical practice.

Interprofessional learning (IPL): Students described participation in IPL activities and demonstrated an awareness of the importance of collaborative working and referral pathways. They recognised the value of multidisciplinary approaches to patient care and understood the role of other healthcare professionals within wider healthcare systems.

The panel welcomed the positive feedback regarding IPL opportunities and considered these experiences important in preparing students for contemporary healthcare practice. Although opportunities remain relatively limited at present, the panel noted a clear commitment to further development in this area.

The panel found students to be articulate, reflective and engaged. Students demonstrated an awareness of both their current capabilities and the areas in which further development would occur as they progress towards graduation. The panel noted, however, that continued monitoring of student exposure to the breadth and complexity of clinical presentations will become increasingly important as further cohorts progress through the programme.

Meeting 4: Placement Providers

Attendees: Five external placement providers (one attended online)

The panel met with external placement providers to explore their experiences of supporting SCC students and to seek assurance regarding the quality and effectiveness of placement learning opportunities.

Placement expectations: Placement providers explained that expectations are aligned to students' stage of development, with increasing responsibility and participation expected as students progress through the programme. Professional behaviour, communication skills, active engagement and appropriate conduct were identified as fundamental expectations from the outset. Providers described placement learning as an important opportunity for students to experience authentic clinical environments whilst developing confidence, professional judgement and workplace behaviours.

The panel noted the commitment of the placement providers to supporting the development of future chiropractors. Providers described student development as a professional responsibility and spoke positively about their role in preparing students for practice.

Clinical development: The panel explored how students develop clinically through placement experiences. Providers described a progressive model in which students move from observation towards increasing participation in patient assessment, communication and clinical activities under supervision. Learning opportunities are adapted according to students' confidence, competence and stage of development.

Providers reflected positively on the progression they had observed in students over time and described noticeable improvements in confidence, communication and professional capability as students returned for subsequent placements.

Patient safety: The panel explored the arrangements in place to ensure patient safety during placement activities. Providers reported that students remain closely supervised throughout placements and that responsibility for patient care remains with the registered practitioner at all times. The panel heard that patient consent forms an essential component of placement activity and that patients are informed about the role of students and able to decline participation if they wish.

Providers also described induction processes designed to familiarise students with clinical procedures, safety requirements and professional expectations before engaging in patient-facing activities.

The panel found evidence of a strong emphasis on patient safety, professional supervision and patient choice. Providers demonstrated awareness of their responsibilities in relation to both patient welfare and student learning. The panel was reassured that patient safety remains the primary consideration within placement activities and that students are introduced to patient care in a supervised and structured manner. The panel noted that as placement provision expands, continued oversight of these arrangements will be important to ensure consistency across the provider network.

Quality assurance: The panel explored the processes used by SCC to recruit, approve and support placement providers. Providers described a structured approval process involving audit, review of facilities and discussion of placement requirements. The panel heard that providers receive guidance regarding student learning outcomes,

responsibilities and relevant policies and that support from SCC staff is readily available when required.

Discussion highlighted formal and informal mechanisms for monitoring placement quality, including feedback from students and providers, progress reviews and ongoing communication with SCC staff. Providers reported that concerns are addressed promptly and that SCC has demonstrated responsiveness to feedback.

The panel was reassured by the strength of the relationships established between SCC and its placement providers. Providers described the programme team as approachable, responsive and supportive.

Student assessment: The panel explored how placement providers contribute to student assessment and development. Providers described a structured assessment process supported by guidance from SCC and emphasised the importance of narrative feedback, reflective discussion and developmental conversations in supporting student learning.

Whilst providers expressed confidence in the assessment process, the panel considered that ongoing moderation and standardisation processes will become increasingly important as student numbers increase and the placement network expands.

Patient-centred care: Providers described how students are encouraged to understand patients as individuals rather than simply clinical presentations.

The discussion highlighted students' exposure to referral pathways, multidisciplinary working and the realities of clinical decision-making. Providers described opportunities for students to observe interactions with other healthcare professionals and to develop an understanding of both the scope and limitations of chiropractic practice.

The panel welcomed the range of examples provided relating to referral pathways and multidisciplinary working. The discussion provided assurance that students are developing an understanding of patient-centred care, referral pathways and professional boundaries.

Governance: The panel explored governance arrangements, mechanisms for raising concerns and opportunities for placement providers to contribute to programme development. Providers demonstrated awareness of reporting mechanisms, student support processes and opportunities to provide feedback through established communication channels. It was also noted that patients have the opportunity to provide informal feedback on interactions with students.

The establishment of the placement and clinic committee was viewed positively and providers reported feeling able to contribute to the ongoing development of placement learning. The discussion provided evidence of collaborative working between SCC and its placement providers and demonstrated that mechanisms were in place to support communication, oversight and continuous improvement. Whilst the panel was assured that placement governance arrangements were operating effectively, it considered that continued development and clarification of governance structures, reporting relationships and lines of accountability across the wider programme and institutional framework would further strengthen oversight as the programme and clinic continue to develop.

Meeting 5: Clinical Team

Attendees: Dr Ross McDonald (SCC Clinical Lead & Senior Clinic Tutor), **Dr Rob Sandford** (Senior Clinic Tutor), **Dr Rebecca Vickery** (Senior Clinic Tutor), **Dr Richard McWilliam** (Clinic Tutor), **Dr Andrew Feltoe** (Clinic Tutor). **Dr Thomas Doig** (Clinic Tutor) attended online.

The panel met with members of the clinical team to explore the organisation, management and quality assurance of both external and internal clinical learning experiences.

Quality assurance: Staff described the arrangements used to recruit, approve and support placement providers and outlined efforts to ensure students are exposed to a range of clinical environments, patient populations and practice settings.

The panel heard that placement providers are selected through a structured approval process involving audit, review of facilities and consideration of the educational opportunities available to students. Clinical staff emphasised that placements are intended to provide meaningful learning experiences that contribute directly to students' professional development.

The panel explored how the institution monitors the quality of external placements following provider approval. Staff described a range of formal and informal mechanisms through which placement quality is evaluated, including student feedback, provider evaluations, reflective activities and committee oversight. Concerns can be escalated rapidly and placement experiences are reviewed routinely to inform ongoing development.

The discussion highlighted a strong emphasis on partnership working between the institution and placement providers. The panel found evidence that placement quality is monitored continuously rather than solely through periodic review processes and that communication channels between stakeholders are well established.

The panel noted that the current model benefits from the relatively small size of the institution and the close relationships established with placement providers. As student numbers increase, continued monitoring of placement capacity, communication arrangements and quality assurance processes will be important to ensure that the current level of oversight and responsiveness can be maintained.

Governance structure: The panel explored the governance arrangements supporting clinical education and placement activity. Staff described a layered governance structure involving programme and clinical practice committees. Students are represented within these structures and are able to contribute to discussions relating to programme and clinic development.

The panel recognised that progress had been made in establishing committee structures and mechanisms for oversight. However, governance arrangements remain in a developmental phase and the panel considered that greater clarity regarding reporting relationships, delegated responsibilities and lines of accountability across SCC and BNU structures would further strengthen institutional oversight and support future growth.

Student voice: The panel explored how students experience the teaching clinic and how feedback is gathered from those participating in internal placements. Staff described formal and informal mechanisms through which students can raise concerns and

contribute suggestions for improvement. The panel heard that feedback has informed developments to clinic facilities, communication systems and operational processes.

The discussion recognised that, as the clinic continues to expand and serve a growing public patient population, further refinement of systems and processes will be required. The panel found evidence that student feedback is being used effectively to support the ongoing development of the clinic environment and that staff are responsive to operational issues as they emerge.

Assessment: The panel explored the methods through which student performance is assessed within the clinic environment. Staff described a developmental model of assessment in which observation, feedback and reflection are used to support progression towards competent independent practice. Students receive feedback from multiple tutors and are encouraged to engage actively with reflective practice and professional development.

The panel also heard about the introduction of a digital assessment and feedback platform intended to improve consistency of feedback and support quality assurance processes.

The panel welcomed the emphasis placed on developmental feedback and reflective learning. Students appear to be encouraged to engage actively with feedback and take responsibility for their own professional development. The proposed introduction of a digital assessment platform was also viewed positively. As implementation is still ongoing, the effectiveness of the system will need to be evaluated as further cohorts progress through clinical training.

Collaborative working: The panel explored how students are prepared to work collaboratively within wider healthcare systems and multidisciplinary environments. Staff described opportunities for students to engage with referral processes, communication with other healthcare professionals and consideration of wider health issues affecting patient care. The discussion also highlighted examples of collaboration with other professional groups through community-based and educational activities.

The panel welcomed the programme team's commitment to preparing students for collaborative practice and was assured that students are developing an understanding of referral pathways, professional boundaries and the role of other healthcare professionals in patient care. However, the panel considered that there would be value in further strengthening engagement with a broader range of external stakeholders, both within and beyond the chiropractic profession, to support programme development, clinical education and graduate preparedness. The programme team's ambition to expand multidisciplinary opportunities as the clinic develops was therefore welcomed.

Quality assurance: The panel explored the arrangements used to ensure consistency, fairness and reliability in assessment. Staff described moderation processes involving clinical tutors, senior clinical tutors, programme leaders and external examiners. Students are assessed by multiple tutors and assessment decisions are reviewed through regular meetings, moderation activities and structured discussions.

The panel also heard that quality assurance processes extend across both clinical and academic assessment and that moderation reports are reviewed through governance procedures with input from external examiners.

The panel was reassured by the moderation and quality assurance processes currently in place. However, maintaining consistency and standardisation across a growing clinical

teaching team will require ongoing review as student numbers increase and clinic activity expands.

Student Workload, Professional Behaviours and Readiness for Practice: The panel explored how students balance the demands of academic study, clinical learning and personal commitments. Staff described a programme structure that gradually increases clinical responsibility while maintaining expectations regarding professional conduct, preparation and accountability. Clinical education is intended not only to develop technical competence but also the professional attitudes and behaviours required for independent practice.

Staff linked clinic expectations to future professional practice and demonstrated a commitment to preparing students for the realities and responsibilities associated with registration. The discussion suggested that students are being supported not only to develop clinical competence but also the professional behaviours expected of registrants.

The panel recognised that some aspects of clinical learning are currently influenced by the size of the clinic. Whilst staff provided examples of students encountering increasingly complex presentations, the panel considered that continued growth in patient numbers and diversity of case mix will provide further opportunities for students to develop confidence in managing the breadth and complexity of presentations likely to be encountered in independent practice. The panel also noted the significant clinical commitments expected of students during the final year of the programme and considered that ongoing review of workload and notional learning hours would be beneficial to ensure an appropriate balance between academic study, clinical learning, independent learning and wider personal commitments.

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, with approval to take effect from September 2026*

It was agreed that the approval report would be shared with the College for fact checking by 19 June 2026 for return to the GCC by 26 June 2026. The report will be presented to the Education Committee at its July 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.

*If approved by the GCC Council, approval would take effect from the commencement of Year 1 of the programme in September 2026. Students within the current cohorts will be subject to the requirements of Condition 5, which requires the College to undertake a comprehensive mapping exercise and develop cohort-specific action plans, for GCC approval, to ensure that gaps in achievement of the GCC Education Standards arising from study undertaken prior to approval are identified and addressed.

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 and timeframe in which they must be met.

1. Further develop and implement a comprehensive Student Support Policy and Procedure that clearly sets out arrangements for student wellbeing, disability support, personal tutoring, students in crisis, escalation processes and associated responsibilities, by January 2027.
2. Further develop and document the governance framework for the programme and institution, including clear reporting lines across SCC and Buckinghamshire New University committee structures. This should include committee terms of reference, delegated responsibilities, membership and reporting arrangements, by January 2027.
3. Review and revise the curriculum, teaching, learning and assessment strategy to explicitly demonstrate alignment with contemporary evidence-based practice, including the appropriate use of diagnostic imaging, ongoing patient management, review of care and cessation of care. Evidence of the review, the changes identified, and their implementation must be submitted to the GCC by July 2027.
4. Develop and implement a strategic plan for Patient and Public Involvement (PPI) that demonstrates meaningful engagement across the design, delivery, evaluation and enhancement of both the programme and the clinical environment, by July 2027.

Transitional condition for current students

This condition applies only to students who commenced the programme **before GCC approval** and is intended to ensure they are able to demonstrate achievement of the GCC Education Standards at graduation.

5. Undertake a comprehensive mapping exercise for students within each of the previous three intake cohorts to identify and evaluate gaps in learning, assessment and achievement of the GCC Education Standards arising from study undertaken prior to GCC approval. Following completion of the mapping exercise, the College must submit to the GCC a separate detailed action plan for each cohort, including timescales, responsibilities and monitoring arrangements, demonstrating how all identified gaps will be addressed to ensure that every student is able to meet the GCC Education Standards by the point of graduation. No action plan may be implemented without prior GCC approval. Evidence of progress against the approved plans will be subject to ongoing GCC monitoring. The completed mapping exercise and cohort-specific action plans must be submitted to the GCC by December 2026.

6. The programme will be subject to annual monitoring visits by the GCC for a period of four years commencing in September 2026

Recommendations for the institution

1. Develop further opportunities for students to acquire and demonstrate leadership knowledge, skills and behaviours appropriate to a regulated healthcare professional.
2. Further strengthen engagement with a broader range of external stakeholders, both within and beyond the chiropractic profession, to support programme development, clinical education and graduate preparedness.
3. Implement a systematic process for monitoring student exposure to the breadth, depth and complexity of clinical presentations encountered within the internal clinic to ensure students meet academic and clinical requirements and competencies.
4. Further develop the processes used to monitor, support and quality assure external placement providers on an ongoing basis.
5. Review the notional learning hours and student workload within the fourth year of the programme to ensure an appropriate balance between academic, clinical, independent learning activities and balances personal commitments.
6. Continue to monitor and review moderation and standardisation processes across the programme, with particular attention to assessments undertaken within clinical and practice settings.
7. Review the distribution of leadership, operational and academic responsibilities within the Senior Management Team to ensure that workloads are sustainable and organisational resilience is strengthened as the institution develops.

Commendations to the institution

1. The high-quality facilities, learning resources and clinical environment that provide an excellent setting for student learning and professional development.
2. The provision of hardship funding and associated support mechanisms that contribute positively to student wellbeing, retention and success.

General Chiropractic Council

To note

Report from the Chair of the Remuneration and HR Committee

Purpose

To provide Council with an update on the key matters considered by the Remuneration and Human Resources Committee at its meeting on 16 July 2026, including the Committee's decisions, recommendations and areas of ongoing work.

Summary

The Committee considered a range of matters relating to remuneration, people, organisational development and Council succession planning.

The Committee welcomed the exceptionally positive employee engagement survey results and the progress made in strengthening organisational capacity during 2026. It also approved a number of revised HR and remuneration policies, subject to minor drafting amendments.

A significant part of the meeting focused on Council succession planning. The Committee endorsed the overall approach to Associate Members, Council member reappointments and future recruitment, including the need for a more proactive and transparent process.

The Committee also reviewed the GCC's non-pay benefits package and agreed that further staff engagement should inform any future development of the package.

Matters for Council to note

Council is asked to note:

a) Employee engagement: The exceptionally positive results from the employee engagement survey and the Committee's ongoing oversight of the resulting action plan, including the areas identified for further work.

b) HR and remuneration policies: The Committee's approval of revised Learning and Development, Recruitment, Council and independent members' Remuneration, and Executive Directors' Remuneration policies, subject to the agreed drafting amendments.

c) Council succession planning: The Committee's endorsement of the overall approach to Associate Members, Council member reappointments and future recruitment, including the need to fill two registrant vacancies, one of which must be from Wales.

d) Non-pay benefits: The Committee's conclusion that the current benefits package is comprehensive, together with its support for further staff engagement on future priorities. Any proposals involving material additional costs will return to the Committee.

e) Performance and remuneration: The Committee's intention to consider how Executive Director performance feedback, appraisal outcomes and remuneration oversight can be more closely aligned.

The sections below provide a summary of the main matters considered by the Committee at its meeting on 16 July 2026.

1. Staff engagement and organisational development

The Committee reviewed the results of the employee engagement survey, which were exceptionally positive, with particularly strong results in leadership, collaboration, organisational culture and staff voice. The Committee congratulated the Executive and staff on the results and the wider work undertaken to support staff engagement.

The Committee noted that workload and timescale pressures remained the lowest-scoring area, although this had improved substantially from previous years. It agreed that future reporting on the survey should be proportionate and focused on actions and progress rather than lengthy narrative.

The Committee also noted three areas for further consideration arising from the staff engagement work:

- IT capability and digital confidence;
- psychological safety and arrangements for staff to speak up; and
- the understanding, communication and development of the non-pay benefits package.

The Committee will receive light-touch reporting on progress against the staff survey actions.

2. HR policies

The Committee approved revised policies covering:

- Learning and Development
- Recruitment
- Remuneration for Council and independent members, and
- Executive Directors' Remuneration.

The approvals were subject to a small number of drafting amendments and clarifications.

In relation to remuneration, the Committee agreed that future decisions on Council and independent member remuneration should consider quarterly CPIH data alongside relevant future inflation forecasts, without creating an automatic or mechanistic link to any particular forecast.

For Executive Directors' remuneration, the Committee agreed that a full external benchmarking exercise should not automatically be undertaken every three years. Instead, a lighter-touch review will be undertaken, with a fuller exercise commissioned where there are relevant triggers, such as recruitment difficulties, salary drift, significant market movement or a significant vacancy.

3. Council succession planning

The Committee endorsed the overall direction of the Council succession planning arrangements. It supported a more proactive and transparent approach to Associate Member recruitment, Council member reappointments and new appointments.

Associate Members

The Committee agreed that:

- two Associate Members should continue to be appointed where the quality and spread of candidates justify this;
- Associate Member terms should remain at two years; and
- feedback should be obtained from current Associate Members on their experience, including term length, induction, support and how quickly they were able to contribute.

The Chair and Jonathan McShane will be involved in this feedback exercise.

Reappointments

The Committee agreed that reappointment to Council should not be treated as automatic. The process should consider continued motivation, contribution, energy and commitment.

It also agreed that the formal reappointment process should be the final stage of a wider appraisal and feedback process, rather than the point at which concerns about contribution or attendance are first raised. Any such concerns should be addressed through the regular appraisal process in advance.

The Committee noted the timetable for Catherine Kelly's reappointment and the need to ensure that the relevant appraisal and reappointment evidence is in place in good time. It also considered how the reappointment processes for Sam Guillemard and Aaron Porter could be aligned with their annual appraisals to avoid unnecessary duplication.

Future recruitment

The Committee noted that two registrant Council vacancies will need to be filled, one of which must be from Wales. It discussed the desirable balance of skills and

experience for future appointments, including the potential value of candidates with current practising experience and/or a research background.

The Committee requested that the recruitment and succession timetable be presented in three clear sections covering Associate Members, reappointments and new appointments. This is intended to improve clarity while allowing the same panel or process to be used across more than one workstream where this is efficient.

4. Non-pay benefits

The Committee reviewed the GCC's current non-pay benefits package and noted that it was comprehensive and compared favourably with many organisations.

The Committee supported further staff engagement to understand which benefits are valued and where improvements or better communication may be appropriate. It noted that some existing benefits, including private medical cover, appeared to have relatively low uptake.

Any new proposals with material financial implications will be brought back to the Committee and considered as part of the wider pay and reward package.

5. Forward work programme

The Committee agreed that further consideration should be given to how Executive Director performance feedback and appraisal outcomes can be more closely aligned with the Committee's oversight of remuneration and reward.

This will be developed as part of the Committee's future work programme.

6. Next meeting

The next meeting of the Committee is scheduled for 11 November 2026 and will be held in person.

Paul Allison
Chair of the Remunerations and HR Committee

General Chiropractic Council

For noting

Mediation pilot scheme – The chiropractic complaints mediation service (CCMS)

Purpose

This paper updates Council on the launch of the Chiropractic Complaints Mediation Service (CCMS), a time-limited pilot delivered independently by Nockolds Resolution. It summarises progress since June 2026, the safeguards built into the pilot, stakeholder engagement and review arrangements.

Summary

- In June 2026, Council agreed that we explore mediation as a proportionate route for suitable lower-level complaints at the front end of the Fitness to Practise pathway. The aim was to improve complainant and registrant experience while focusing regulatory resources on more serious concerns.
- The CCMS launched on 1 September 2026 as a time-limited pilot delivered independently by Nockolds Resolution. It provides an additional route for resolving suitable concerns through constructive dialogue and does not replace our statutory Fitness to Practise functions. Its scope and safeguards have been informed by engagement with Council members, academics, regulators, defence bodies, registrant groups and Nockolds.
- Public protection remains central. Serious concerns, misuse of protected title and matters requiring regulatory consideration will continue through our statutory processes. Council will receive a formal evaluation in March 2027, with an interim update in December 2026 if required.

Recommendations

Council is asked to note:

1. the launch of the Chiropractic Complaints Mediation Service on 1 September 2026;
2. the stakeholder engagement and assurance work undertaken since the June 2026 Council meeting;
3. that the service is an independent, time-limited pilot delivered by Nockolds Resolution;

4. the service is currently funded by us within existing FtP budget;
5. that the service does not replace our statutory Fitness to Practise functions and will not be used for Section 32 matters;
6. that a formal review will return to Council in March 2027, with verbal updates in December 2026 if needed.

Background

1. The June 2026 paper set out the rationale for exploring mediation within the early part of the FtP pathway. Some concerns are unlikely to require formal regulatory investigation but can still involve distress, poor communication, unmet expectations or breakdown in the practitioner-patient relationship. A pilot mediation service could offer a proportionate and constructive route while allowing us to focus on cases that raise public protection issues. That paper also recognised the need for clear safeguards, eligibility criteria and escalation arrangements. Those principles have guided the work undertaken since June.

2. Since then, the project has moved from concept to launch. The CCMS launched on 1 September 2026 as a time-limited pilot to test whether suitable lower-level concerns can be resolved earlier, more constructively and in a way that improves complainant and registrant experience.

3. Work since June has focused on design, assurance, readiness and delivery, including finalising the scope, eligibility criteria, public protection safeguards, escalation routes back to my team and the evaluation framework.

4. Stakeholder engagement has been central to developing the pilot, including discussions with Council members, academics researching witness to harm, other regulators, defence bodies and their legal representatives, registrant groups and Nockolds.

5. This engagement has helped ensure the model is proportionate, clear and appropriately positioned as an additional route for suitable concerns, not an alternative to regulatory action where public protection issues arise.

6. The CCMS is intended for suitable lower-level concerns where constructive dialogue may assist, including issues about communication, expectations, customer service, fees, appointment management or breakdown in the practitioner-patient relationship.

7. The service will not be used for matters requiring formal regulatory investigation or urgent regulatory action, including patient safety, serious misconduct, safeguarding, dishonesty, abuse, serious clinical concerns, criminal matters,

repeated concerns, misuse of protected title or wider risk to patients or the public. It will not be used for Section 32 title matters.

8. Escalation routes have been built in so unsuitable matters, or concerns that raise potential fitness to practise issues, can be referred to GCC for consideration under the appropriate statutory process.

Review and reporting

9. The pilot will be evaluated on whether it provides a safe, proportionate and effective route for suitable complaints; improves complainant and registrant experience; supports earlier resolution; reduces avoidable demand on FtP; maintains public protection; and represents value for money.

10. A formal review will return to Council in March 2027. Oral updates may be provided in December 2026 if early activity, operational learning or emerging issues require Council awareness before then.

Hannah Fellows

Director of Fitness to Practise

General Chiropractic Council

For noting

Safeguarding & criminal record checks

Purpose

To provide Council with an update on our review following changes to the external regulatory and legislative landscape. The review sets out our arrangements for ensuring the integrity of those admitted and retained on the Register, relevant developments across the UK, benchmarking with other professional regulators, and the emerging direction of travel for strengthening assurance where it is proportionate to do so. Council is asked to discuss the paper **Annex A**, note our emerging direction of travel; with comments invited.

Summary

1. We assess good character and suitability for registration through a risk-based approach, principally using applicant and registrant declarations, ongoing notification requirements and targeted regulatory action where relevant concerns arise. Criminal record information forms part of this wider framework of assurance.

2. During 2026, the context in which these arrangements operate has changed. Legislative developments have increased access to criminal record checks for eligible self-employed practitioners, including through DBS in England and Wales and AccessNI in Northern Ireland. Scotland operates a separate statutory safeguarding framework through Disclosure Scotland and the Protecting Vulnerable Groups (PVG) Scheme.

3. The Professional Standards Authority (PSA) has also strengthened its Standards for Regulators concerning professional suitability at registration and on an ongoing basis. The PSA has indicated in its new Standards of Good Regulation that regulators should take a proportionate, profession-specific approach and be able to demonstrate how their assurance arrangements respond to identified risks.

4. In response, we wanted to review existing arrangements, consider available evidence concerning non-disclosure of criminal matters and benchmark our approach against other UK professional regulators. The review indicates that

there is no uniform approach to criminal record checking across professional regulation. Most regulators considered continue to rely primarily on declarations and targeted checks, while the General Osteopathic Council is unusual in requiring criminal record checks routinely at initial registration.

5. Our existing arrangements provide safeguards, but where we rely on self-declaration there is a risk that relevant information may not always be brought to our attention. A review of fitness to practise data identified that 16 of 18 criminal or police-related matters identified between 2021 and 2026 were recorded as not previously declared or declared late.

6. Routine checking of all registrants would introduce additional cost and administrative burden and could duplicate checks undertaken elsewhere. Criminal record checks provide assurance at a particular point in time and do not obviate the requirement for ongoing declaration, information-sharing and fitness to practise arrangements.

7. Having undertaken a review our preference is to retain the current declaration-led model, but to supplement with risk-based criminal record assurance where circumstances indicate that is appropriate. This could include initial registration where concerns arise or a significant gap between graduation and an application to join the Register; at retention where relevant information or concerns arise, and restoration following a significant period away from the Register or where concerns are identified.

8. Further work will develop the proposed risk-based approach, including the circumstances in which additional criminal record assurance should be sought, the evidence required and how equivalent assurance across the UK would be recognised. Legal, equality, financial, information governance and operational implications will also be considered before any changes are implemented. Once finalised, our approach will be published on the Health and Good Character and initial registration pages of the GCC website, with implementation targeted for early December 2026.

Alignment to strategy, risks and budget

- Supports our public protection responsibilities by strengthening assurance that those joining, remaining on or returning to the Register continue to be suitable for registration.
- Responds proactively to changes in the regulatory and safeguarding landscape and supports continued alignment with the PSA Standards of Good Regulation.

- Addresses the residual risk associated with reliance on self-declaration while recognising the limitations of criminal record checks and the need for a proportionate response.
- Supports public confidence in the Register and demonstrates that we are actively assessing and developing its regulatory controls.
- There are no immediate financial implications arising from this paper. Potential costs to us and our registrants will be assessed as part of the development of any future model.
- No immediate equality, diversity and inclusion implications arise from Council noting this paper. Any future changes to criminal record checking requirements will require appropriate equality and proportionality assessment.

Recommendations

Council is asked to note:

- the changing regulatory and legislative landscape relating to criminal record checks;
- our current approach and assessment of the associated risks;
- the benchmarking undertaken across professional regulators and consideration of the different criminal record checking arrangements operating across the UK; and
- our direction of travel towards proportionate, risk-based strengthening of criminal record assurance where appropriate, and is invited to comment accordingly.

Aaron Grell

Registration Manager

General Chiropractic Council

Annex A - Safeguarding & Criminal Record Checks

Annex A – Safeguarding criminal record checks

1. Purpose

The underlying regulatory question considered in this paper is how the GCC obtains proportionate assurance that applicants and registrants are of good character and remain suitable for registration. Criminal record information is one source of that assurance, alongside declarations, information received from third parties and our fitness to practise processes.

We rely now primarily on declarations and targeted regulatory intervention rather than routine independent criminal record checking. Changes to the regulatory and legislative landscape during 2026 provide an appropriate opportunity to consider whether these arrangements continue to provide sufficient and proportionate assurance.

Council is asked to note this review and next steps.

2. Our current approach

We do not routinely require all applicants or registrants to provide evidence of a criminal record check. We currently assess good character and suitability for registration through a combination of declarations, ongoing notification requirements, targeted regulatory intervention and information received through other routes.

This includes:

- declarations from applicants and registrants concerning relevant criminal and other matters;
- an obligation on registrants to notify the GCC of relevant convictions, cautions and charges;
- targeted checks or requests for further evidence where concerns are identified;
- consideration of relevant information through Registrar and fitness to practise processes; and
- wider assurance provided through education, employment and other safeguarding arrangements.

For UK chiropractic programme graduates, criminal record checking takes place through education providers before a student undertakes clinical placements. The education providers also submit a character reference to us in line with our registration process requirements. These provide us with an important source of assurance at initial registration. However, criminal record checks undertaken by a student may have been completed several years before an individual applies for registration and may not reflect subsequent changes in circumstances. This gap may be greater where a graduate delays their application to us to join the Register

following qualification. Criminal record checks may also be required subsequently by employers or other organisations, depending on the setting in which an individual practises.

Criminal record information therefore forms one part of a broader framework of declarations, information sharing, regulatory assessment and fitness to practise controls. However, reliance on self-declaration creates a residual risk that relevant information may not be disclosed, may be disclosed late, or may not otherwise come to our attention.

3. Changing regulatory landscape

3.1 PSA Standards for Regulators

The PSA has been considering criminal record assurance as part of its wider work on safeguarding and the regulation of self-employed healthcare practitioners.

Its revised Standards for Regulators place increased emphasis on regulators being able to demonstrate proportionate arrangements for assuring professional suitability. In particular:

- **Standard 9 – The Registration Process** requires registration processes to ensure that only individuals who meet the necessary requirements, including professional suitability, are able to register.
- **Standard 11 – Continuing suitability for registration** requires organisations to have proportionate requirements and processes in place to assure that registrants maintain their skills and continue to be suitable to practise.

The PSA has indicated that the appropriate response should be considered on a profession-by-profession basis, with proportionality remaining an important consideration for individual regulators. The revised Standards do not prescribe a particular model of criminal record checking. Rather, they require regulators to demonstrate proportionate and risk-based arrangements for assessing professional suitability at registration and on an ongoing basis.

3.2 Regulatory approaches considered by the PSA

The PSA has considered a spectrum of approaches, from strengthened declarations and targeted checks to routine criminal record checking. It has not prescribed a single model and recognises that the appropriate response should reflect the risks and characteristics of individual professions.

3.3 Evidence of non-disclosure

The PSA's work has also identified evidence that relevant criminal matters are not always declared to professional regulators.

We have also reviewed available information concerning criminal and police-related matters within its own fitness to practise caseload. Of 18 matters identified between

2021 and 2026, 16 were recorded as either not previously declared to us or declared late, while two were recorded as having been self-declared on time. All 18 matters resulted in regulatory investigation or action.

The findings provide evidence of the potential limitations associated with reliance on self-declaration. They demonstrate that criminal or police-related matters may come to our attention through routes other than registrant self-declaration. However, in some cases it has not been possible to establish whether the registrant had been arrested or had otherwise reached the threshold at which they were required to notify us. The data should therefore not be interpreted as demonstrating that all matters recorded as not previously declared represented a failure to comply with our reporting requirements.

The data should also be interpreted with some caution. It represents the available cases identified through the review and should not be used to establish the prevalence of non-disclosure across the Register. Further improvements to structured recording and management information would enable us to monitor this risk more systematically in future.

4. Criminal record checking across the UK

Criminal record disclosure arrangements differ across the UK. This is relevant to our approach, as a UK-wide regulatory requirement cannot be framed solely in terms of obtaining a Disclosure and Barring Service (DBS) check.

Recent changes have also addressed some of the historical difficulties experienced by self-employed practitioners in accessing higher-level criminal record checks.

Jurisdiction	Current arrangements	Relevance to us
England and Wales	DBS operates the criminal record checking framework. From January 2026, eligible self-employed people undertaking relevant activity can access enhanced criminal record checks through an umbrella body.	Removes an important practical barrier to additional criminal record assurance for self-employed practitioners.
Scotland	Disclosure Scotland operates the Protecting Vulnerable Groups (PVG) Scheme. Membership is required for individuals carrying out regulated roles, with five-year PVG membership introduced from April 2026.	Chiropractors undertaking regulated roles in Scotland operate within a distinct statutory safeguarding framework which includes continuing monitoring arrangements.

Jurisdiction	Current arrangements	Relevance to us
Northern Ireland	AccessNI operates the criminal record disclosure framework. From February 2026, eligible self-employed people and personal employees working with vulnerable groups can access enhanced criminal record checks through an umbrella body.	Removes a similar historic access barrier for eligible self-employed practitioners and would need to be recognised within our future model.

These developments have reduced some of the historical barriers to criminal record checking for self-employed practitioners. However, the mechanisms differ across the UK, particularly in Scotland where the PVG Scheme provides a distinct statutory and continuing safeguarding framework. Any future approach by us would therefore need to define the assurance required rather than prescribe a single UK-wide checking mechanism.

5. Benchmarking against other professional regulators

We have considered the approaches adopted by other UK professional regulators.

Regulator	Approach identified
General Osteopathic Council (GOsC)	Requires criminal record checking at initial registration. The process is outsourced and associated administrative costs are borne by applicants.
General Medical Council (GMC)	Does not routinely require criminal record checks at registration; principally relies on declaration. Criminal matters are also considered on restoration.
General Dental Council (GDC)	Does not routinely require criminal record checks at registration. Further checks may be undertaken where an applicant declares a relevant matter.
Health and Care Professions Council (HCPC)	Does not routinely require criminal record checks for all applicants. Relies on declaration, with checks undertaken where required.
Social Work England	Does not routinely require a new criminal record check on registration. The DBS Update Service may be used where relevant criminal information has been declared.

Regulator	Approach identified
General Optical Council (GOC)	Benchmarking undertaken has not identified a routine criminal record checking requirement comparable with the GOsC model.

This benchmarking demonstrates that there is not a uniform approach across professional regulation. Declaration supplemented by targeted regulatory intervention remains the predominant model amongst the regulators considered, while the GOsC requires criminal record checks routinely at initial registration. Our approach must reflect the risks and characteristics of chiropractic rather than blindly following practices elsewhere.

6. Assessment of current risks and potential benefits

The review has considered both the residual risks inherent within the existing model and the potential benefits and disadvantages of introducing additional criminal record assurance.

6.1 Risks within the current model

Non-disclosure: Reliance upon declarations creates a residual risk that relevant criminal information may not be provided to us or may be disclosed late. This risk is supported by our review of available fitness to practise data, which identified that 16 of 18 criminal or police-related matters between 2021 and 2026 were recorded as either not previously declared or declared late.

Self-employment: Chiropractic has significant levels of independent and self-employed practice. Consequently, employer-led safeguarding arrangements may not provide the same level of assurance across the profession as they may in professions predominantly operating within large healthcare organisations.

Currency of assurance: Criminal record checks undertaken during education may be several years old by the point of initial registration, particularly where a graduate delays applying to the Register. Similar considerations arise where an individual seeks restoration after a significant period away from the Register.

Public expectation: There may be a gap between public expectations and actual regulatory requirements. When this issue was previously considered by Council Members, there was a view that members of the public might reasonably expect a healthcare professional to have undergone a criminal record checking process, at least on entry to the Register. This does not in itself establish that routine checking is necessary or proportionate, but it is relevant when considering public confidence in the Register.

6.2 Potential benefits of strengthening assurance

Additional criminal record assurance at appropriate regulatory touchpoints could:

- provide independent assurance rather than relying solely upon declaration;
- strengthen assessment of suitability where existing assurance may be outdated or a concern has arisen; and
- provide additional assurance to patients, the public and other stakeholders.

6.3 Limitations and proportionality

Additional checking would not eliminate regulatory risk. Criminal record checks generally provide assurance about information available through the relevant disclosure system at a particular point in time. They cannot prevent subsequent offending and do not remove the need for ongoing declarations, information sharing and fitness to practise processes.

There is also potential for duplication. Some applicants and registrants will already have undergone criminal record checks through education, employment or other professional activities.

A universal or frequently repeated checking requirement could create additional financial and administrative burdens for registrants and us without necessarily delivering a proportionate increase in public protection.

Any approach must also recognise rehabilitation, fairness and equality considerations. The existence of criminal history does not automatically mean an individual is unsuitable for registration. Regulatory consideration must remain focused on the nature and relevance of the information and the risk it presents to public protection and professional suitability.

7. GCC position and direction of travel

Our existing declaration-led arrangements remain an important foundation for regulatory assurance and are broadly consistent with the predominant approach identified through benchmarking.

We do not consider routine criminal record checking of the entire Register to be proportionate. Such an approach would introduce additional cost, duplication and administrative burden while providing assurance only at a particular point in time.

Our proposed direction is therefore to retain its existing declaration-led model, supplemented by risk-based criminal record assurance where circumstances indicate that additional assurance is appropriate.

This could include:

- **initial registration**, where a concern arises or there has been a significant delay between graduation and application;

- **retention**, where a declaration, information received or another identified concern indicates that further assurance is appropriate; and
- **restoration**, where a concern arises or the applicant has been away from the Register for a significant period.

Any additional assurance would complement rather than replace existing declaration, information-sharing and fitness to practise processes.

8. Next steps

Our declaration-led approach remains broadly consistent with others approaches, but there are opportunities to strengthen assurance where specific risks arise or existing assurance may be insufficient. We see merit in retaining with the addition of proportionate, risk-based additional assurance where appropriate.

Further work will develop the proposed risk-based approach, including the circumstances in which additional criminal record assurance should be sought, the evidence required and how equivalent assurance across the UK would be recognised. Legal, equality, financial, information governance and operational implications will also be considered before any changes are implemented. Once finalised, our approach will be published on the Health and Good Character and initial registration pages of the GCC website, with implementation targeted for early December 2026.

Aaron Grell

Registration Manager

General Chiropractic Council

For noting

Protection of Title review update

Purpose

This paper provides background to a discussion with Council on the GCC's developing approach to protection of title and the enforcement of Section 32 of the Chiropractors Act 1994. The accompanying presentation is intended to share emerging findings and possible directions of travel. No decisions are sought at this stage.

Background

1. Protection of title is a strategic commitment within the GCC's 2026-2030 Strategy, reflecting our objective to protect patients from unregulated and unregistered individuals who may present themselves, either expressly or by implication, as chiropractors. The work originated from Council's consideration of the use of titles such as "animal chiropractor" and subsequent legal advice on the scope and operation of Section 32. Since then, the programme has broadened to consider wider risks of misrepresentation, public understanding of registration, and the range of regulatory levers available to support public protection.

2. During 2026 the executive has reviewed approaches used by other regulators, examined GCC casework and intelligence, engaged with stakeholders, and commissioned public research to better understand how different forms of representation may influence public perceptions. The intention is to develop a more coherent and evidence-based approach which can be tested with stakeholders before any formal policy proposals are brought back to Council.

3. Today's discussion is intended to help shape the next phase of the work rather than seek decisions. Following Council's feedback, the executive will further develop the evidence base, test emerging ideas with stakeholders and refine the options available to the GCC. A more developed approach, including proposals for consultation in early 2027 will then be brought back to Council for consideration in December.

Recommendations

Council is asked to discuss the findings presentation.

Andrew Fielding, Policy & Insight Officer