Declarations of interest: members are reminded that they are required to declare any direct or indirect pecuniary interest, or any non-pecuniary interest, in relation to any matters dealt with at this meeting. In accordance with Standing Orders, the Chair will rule on whether an interest is such as to prevent the member participating in the discussion or determination of the matter.

<table>
<thead>
<tr>
<th>Item</th>
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<tbody>
<tr>
<td>1. Welcome, apologies and declarations of interest</td>
</tr>
<tr>
<td>2. A. Council minutes of 11 December</td>
</tr>
<tr>
<td>B. Matters arising</td>
</tr>
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<td>3. Chair’s report</td>
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<td>4. Governance proposals</td>
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<td>5. Chief Executive &amp; Registrar’s report and PSA update</td>
</tr>
<tr>
<td>6. Performance reports A. Business Performance report</td>
</tr>
<tr>
<td>B. Business plan 2019 – update</td>
</tr>
<tr>
<td>C. Finance report</td>
</tr>
<tr>
<td>7. Investment and Reserves Policies A. Investment Policy</td>
</tr>
<tr>
<td>B. Reserves Policy</td>
</tr>
<tr>
<td>8. Annual reports A. Annual review of Fitness to Practise work performance</td>
</tr>
<tr>
<td>B. Annual report from the PCC</td>
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<tr>
<td>C. Annual report on Registration</td>
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<tr>
<td>D. Annual report on Equality, Diversity and Inclusion</td>
</tr>
<tr>
<td>9. Committee Chair updates A. Audit and Risk Committee</td>
</tr>
<tr>
<td>10. AOB</td>
</tr>
</tbody>
</table>

Close of meeting: 12.30pm
Present
Mary Chapman (Chair of Council) (MC)
Roger Dunshea (RD)
Tom Greenway (TG)
Steven Gould (SG)
Gareth Lloyd (GL)
Sharon Oliver (SO)
Ralph Pottie (RP)
Liz Qua (LQ)
Keith Richards (KR)
Julia Sayers (JS)
Carl Stychin (CS)
Gay Swait (GS)

Apologies
Phil Yalden (PY)

In attendance
Rui Domingues, Financial Consultant (RMD)
Tricia McGregor, Interim Chief Executive and Registrar (TM)
Niru Uddin, Acting Head of Fitness to Practise (NU)

<table>
<thead>
<tr>
<th>C-1812/1</th>
<th>Apologies and declarations of interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>MC opened the meeting by welcoming both Council and the observers present. Apologies had been received from PY.</td>
<td></td>
</tr>
<tr>
<td>There were no declarations of interest.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>C-1812/2</th>
<th>Draft minutes of the meeting of 13 September 2018 and matters arising</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-1812/2A Minutes</td>
<td></td>
</tr>
<tr>
<td>The minutes of 13 September 2018 were agreed as an accurate record of the meeting.</td>
<td></td>
</tr>
<tr>
<td>C-1812/2B Matters arising</td>
<td></td>
</tr>
<tr>
<td>It was noted that the one action outstanding, 1809-05, relating to an analysis of registration numbers, would be completed in the new year after the retention period closed.</td>
<td></td>
</tr>
<tr>
<td>All other matters arising had been completed.</td>
<td></td>
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</tbody>
</table>
Chair’s report

The Chair’s report was noted and MC provided a further verbal update on specific issues.

CER Recruitment – MC shared with Council that since writing her Chair’s report the appointment had been finalised and she was delighted to announce the new CER would be Nick Jones, currently the Director of Compliance and Information at the Human Fertilisation and Embryology Authority. MC had attended a GCC staff team brief session to share the news directly with staff. Nick’s start date has been confirmed as the 18th February 2019. Discussion took place on managing the risk of transition to a new CER during a period of significant change. MC confirmed that the continuity of the GCC’s new strategy remains Council’s key focus and responsibility and that planning for an effective transition and handover with TM has already commenced.

Audit and Risk Committee – MC re-iterated her congratulations and thanks to Roger Dunshea as incoming Chair of the Audit and Risk Committee (ARC). She also thanked Liz Qua for both her work as a member of Council and specifically her work as Chair of ARC. It was noted Liz would continue as a member of the ARC until the end of her term on Council in June 2019.

Regulatory reform - MC added that there had been nothing in her report on regulatory reform owing to a further delay to the publication of the results of the consultation. She explained that she and TM had held a conference call with Claire Armstrong at DHSC which had been very helpful. Claire had confirmed that an update on reform plans was now not expected until some point in the New Year.

Chief Executive & Registrar’s report

TM introduced her report that provided an update on a range of activities since the previous Council meeting. The report was taken as read and specific items were highlighted.

PSA Standards of Good Regulation

TM drew Council’s attention to the new PSA standards of regulation, saying that of particular note was the addition of new standards including the diversity of the profession, a regulator’s focus on its core purpose, applying learning, consultation/engagement and how a regulator addressed its performance and any concerns internally. TM reminded Council that a ‘compare and contrast’ review would need to be completed so that the GCC can be assured it is ready to be assessed against the new standards. Consideration will also need to be given as to whether the GCC wishes to pilot the new standards.

Action: TM to inform Council of the decision.

Whistleblowing Prescribed Person’s Duty

TM commented further on the publication of the joint report from all the healthcare regulators noting that this collaboration had been welcomed by all. TM highlighted the nil return from the GCC and the difficulty in interpreting what this meant. It was noted that levels of whistleblowing under the duty varied considerably between regulators and that our nearest regulator in terms of size and type of profession (General Osteopathic Council) had two reported cases. Council discussed the issue further and concluded that the GCC should do more to promote its role as a
prescribed person perhaps in the newsletter and on the website (both of which are being improved during the year). MC requested that the GCC should ensure whistleblowing access is suitably confidential and the process is accessible.

**Action:** Improved information on whistleblowing prescribed person duty to be included on the website by the end of March 2019.

It was also noted that the GCC’s own Whistleblowing Policy is being revised and that the ‘prescribed person’ for staff employed by any of the healthcare regulators is the Professional Standards Authority so if a staff member felt unable to whistle blow using an internal policy, they would have access to the PSA.

**Action:** TM to ensure whistle blowing prescribed person duty is communicated and accessible.

**Development work**

TM discussed the continued review and development work taking place in the GCC and spoke in more detail about the business process reviews. These have identified ways in which the GCC’s process and approaches could be more ‘right touch’ and provide greater assurance on compliance.

**Professional Bodies**

TM also highlighted the very positive and constructive meeting held in October with the Professional bodies. She noted that the results of further engagement with the profession on the strategy were covered in more detail in the Agenda item on the GCC’s five year strategy.

<table>
<thead>
<tr>
<th>C-1812/5</th>
<th>Performance report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C-1812/5A Operations</strong></td>
<td></td>
</tr>
<tr>
<td>TM presented the performance report which was taken as read. A number of specific points were discussed in more detail.</td>
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<tr>
<td><strong>Section 32 (misuse of title)</strong></td>
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<tr>
<td>TM reminded Council that both the public and registrants consider this an important area of work. She brought attention to the team’s current focus on clearing a backlog of s.32 cases and to then agree an approach to manage these in a timely manner as a matter of routine. She highlighted that the GCC had taken a risk-based approach to the backlog and had prioritised the complaints from patients. Steady progress was noted and a number of questions from Council members were discussed. The backlog of Sec 32 complaints included some from 2016 and the current reporting rate runs at about 2-3 per month, hence the need to investigate/resolve the historical cases and implement an ongoing effective procedure. NU explained that some cases are quicker to resolve than others and that ‘cease and desist’ letters did not necessarily mean that cases had been closed as it was possible further action might need to be taken. However, she expected that the backlog of cases should be able to be completed by March 2019. It was noted that this would have an impact on the budget for 2019 and this had been included in the budget setting process.</td>
<td></td>
</tr>
<tr>
<td><strong>It was also noted that it was important to communicate and engage more effectively</strong></td>
<td></td>
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</table>
with the public and registrants about the work the GCC is doing to protect the title ‘chiropractor’. TM and NU noted that the development and improvement of Sec32 work was part of the GCC’s business process review work.

**Action:** TM to ensure section 32 work and outcomes are communicated to the profession and stakeholders.

**Advertising cases**

Council was pleased to see the steady progress on taking advertising cases to Investigating Committee. It was noted that additional Investigating Committee meetings were needed as IC were concluding fewer cases per day than originally estimated. This meant that the expected completion date was 6-8 weeks later than the initial target. However, the GCC was on target with the revised project plan and the expected completion date of April 2019. NU provided updated figures after a fifth week of advertising IC meetings. Of the 293 complaints, 113 had been closed with no case to answer, 7 had been adjourned for further information and none had been referred to the PCC.

Council agreed it would be important to follow up the advertising investigations work with ‘lessons learned’ or similar via the GCC newsletter and any other relevant channels. In discussing guidance related to advertising, TM said that consideration needed to be given about what, and how much, would be useful for registrants. It would be important to be clear on the role of the ASA versus the GCC or professional bodies.

**Action:** NU to ensure learning is shared with the profession following the conclusion of the advertising investigations.

Council discussed the costs of the work and the cost of each case, suggesting that in future there should be a clearer unit cost. Council agreed that it would be useful to see the current baseline unit cost so that we could monitor progress and changes. Discussion took place regarding the benefit that a more right touch investigation process could bring.

**Action:** RMD to provide a baseline unit cost for the current FtP process.

In answer to a query about investigating anonymous cases, which some other regulators did not do, NU confirmed that the GCC’s current processes and procedures meant that the GCC had to investigate these. This issue is included in the FtP business process review.

**Business plan monitoring**

TM gave particular thanks to the GCC team for all their work on the plan, saying that the majority of the items were now listed as green and that any amber items were expected to be completed in early 2019. This had been achieved alongside a period of significant review and change.

MC commented that the CER report cover sheet indicated there were no financial implications, however it was clear that a number of issues had/would require additional funding. The budget should make provision for these.

**C-1812/5B Finance**

It was noted that the Council meeting date, earlier in the month than usual, meant that full management accounts were not yet available. RMD provided a verbal
<table>
<thead>
<tr>
<th>C-1812/6</th>
<th>PSA 2017/18 review and action plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>TM introduced the action plan that had already been reviewed by the Audit and Risk Committee and was being shared with full Council given the importance of the review. The action plan was taken as read and fully supported.</td>
<td></td>
</tr>
<tr>
<td>TM updated Council regarding action 6.39, where the Chiropractic Act does not allow for a final PCC to impose an interim order of conditions which means that a registrant subject to a sanction of conditions could practice until the end of the 28-day appeal window, or in the case of appeal, until the appeal is resolved (6.39). MC and TM had discussed this risk with Claire Armstrong at DHSC and it was agreed that the GCC should carry out a review and obtain advice on that particular issue and present the results of the review to the DHSC. NU noted that GOsC also had the same issue so it may be appropriate for the GCC and GOsC to work together on gaining legislative change in this area.</td>
<td></td>
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<tr>
<td>In relation to action 6.38 (process for handling convictions), it was queried whether the listed completion date of August 2019 was too late as the GCC would be exposed to ongoing deficiencies in the process which would be a significant risk. TM explained that full new guidance was expected to be issued by August 2019 as part of the business process review work, however, interim processes had been put in place in the meantime to ensure that all declared convictions were handled in accordance with the Act. It was agreed the GCC plan should be updated to better reflect this assurance.</td>
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<tr>
<td><strong>Action:</strong> NU to further discuss with GOsC and to complete the review of issue 6.39 and discuss options for change with DHSC by March 2019</td>
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<tr>
<td><strong>Action:</strong> GCC plan on point 6.38 to be updated by TM to clarify that interim new process is in place.</td>
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<thead>
<tr>
<th>C-1812/7</th>
<th>Five year strategy 2019-2023</th>
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<tbody>
<tr>
<td>MC introduced the agenda item, reminding Council members that the strategy had already been discussed at the September Council meeting. It had since been subject to stakeholder and registrant engagement resulting in further developments and changes to the more detailed objectives. She also said that it formed the foundation of the business plan and budget being discussed in the next agenda item.</td>
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<tr>
<td>TM said that that there had been considerable consultation and engagement with the profession and stakeholders with a number of face to face meetings and attendance at the professional association conferences. She reminded Council members that the flip charts and post it notes were displayed on the walls for all to view today. She highlighted there was much common ground between the GCC, registrants and stakeholders. There was a clear message from registrants that they wanted to be part of a regulated profession but wanted to see more right-touch regulation. In addition, she said she had received a lot of comments around CPD, developing the profession and engagement with the profession.</td>
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<tr>
<td>MC stressed the importance of the work on the new five year strategy. She was</td>
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</table>
delighted that the team and TM had been able to engage effectively with so many registrants and stakeholders to complete the work and reach a consensus. Council discussed the five year strategy and supported the strategic aims and objectives set out in the paper.

A particular question was raised around the wording in the background section of the cover paper. It was queried what was meant by the term ‘representative’ in the bullet point “Strong view that the GCC needs to be more representative of the range of chiropractic approaches it regulates”. TM explained the engagement exercise had identified there is a perception that the GCC’s work with, and use of, registrants is not sufficiently reflective of the broad range of chiropractic approaches in use. This is felt to create a situation where the wide range of treatment approaches used in the profession are regulated using a narrower ‘lens’. Council agreed that it was important to act on the feedback received and that the GCC should endeavor to see what evidence there was underpinning the perceptions and consider what further action could be taken.

Discussion also took place regarding funding for different elements of the strategy. TM and RMD confirmed that budget setting for the business plan each year would need to reflect the various areas of work needed to deliver the strategy year on year. Council also discussed the potential risk to the delivery of the strategy with a new CER being appointed. MC reminded Council members that it was Council’s responsibility to hold the CER and senior team to account for the delivery of the strategic aims and objectives. TM confirmed the risk around transition to a new CER had already been added to the risk register, discussed at Audit and Risk Committee and was a key part of the induction and handover planning between TM and NJ.

Action: TM to identify any baseline data on the range of chiropractors currently involved in work for the GCC and consider further action if necessary.

Agreed: Council approved the strategy.

C-1812/8 2019 Business Plan and Budget

Council discussed the business plan and budget together as they are inextricably linked. MC reminded Council that both had been discussed in some detail as a draft via a teleconference held since the September Council meeting.

TM spoke to the business plan noting that the same strategic aims and objectives have been used in the 2019 business plan to provide the ‘golden thread’ ensuring the first year of delivering the strategy is clearly aligned to the long term plan. She noted that the plan was ambitious, however laying a sufficient foundation of work was crucial. She also discussed the importance of the staff team and the ongoing culture work as key to success and had therefore included more detailed information on work to progress in this area.

RMD explained that staff members had been much more involved in devising the budget which gave wider accountability for the budget and greater assurance that it reflected the requirements. He also said the budget was a prudent one. He gave examples of this such as the budget allowed for 110 days of hearings (22 cases of 5-day duration) but that hearing days in 2018, by comparison, had been closer to 70 days.

A range of discussion took place regarding the business plan and the budget including:
- The extent of 2019 not just as a loss making year but as an important
<table>
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<tr>
<th>CO-1903-2A</th>
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<tr>
<td>foundation and investment year for the GCC</td>
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<tr>
<td>- The requirement to draw down from the GCC’s portfolio to fund the loss but in the context of a five year financial strategy.</td>
</tr>
<tr>
<td>- Importance of the IT strategy for better service and improved communication/engagement but also the need to ensure registrants and staff have the skills to make best use of the new approaches</td>
</tr>
<tr>
<td>- Careful consideration to be given to managing transitions during a period of significant change</td>
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<td>- In considering research in chiropractic, to ensure qualitative as well as quantitative research is considered.</td>
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<tr>
<td>- Support for the level of clarity provided in the budget setting approach</td>
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<tr>
<td>- The need to consider proportionality in what we do – a theme that links with ‘right touch’ and good risk management</td>
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Agreed: Council approved the 2019 business plan and budget.

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<thead>
<tr>
<th>C-1812/9</th>
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<tr>
<td>Audit and Risk Committee report</td>
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<tr>
<td>LQ presented her report to Council which was taken as read.</td>
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<thead>
<tr>
<th>C1812/10</th>
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<tbody>
<tr>
<td>Education Committee report</td>
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<tr>
<td>SO provided a verbal update from the Education Committee’s last meeting and noted that the majority of information was contained in the Education Committee’s Annual Report (item C1812/12).</td>
</tr>
<tr>
<td>SO highlighted one item that was discussed at the last Education Committee and is work in progress. This related to the approach taken to the use of, and definition of, the registration category ‘non practising’. The committee had noted that the original use of this category was intended for registrants on maternity leave or sick leave for example. In some cases it was now being used by registrants who did not physically treat patients, an example being some university lecturers or researchers. In other regulated professions the term ‘practising’ has a wider and more relevant meaning. The Education Committee concluded that a wider interpretation of the definition that included teaching, research, management and leadership in chiropractic to be part of ‘practising’ was appropriate and that further work would be undertaken by the staff team to finalise the details of new guidance. It was noted this issue had been discussed with senior education teaching staff during the strategy engagement sessions.</td>
</tr>
<tr>
<td>Action: A proposal for final agreement should be brought to the March Council meeting.</td>
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<tr>
<th>C1812/11</th>
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<tr>
<td>Approval of MCC MChiro degree programmes</td>
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<tr>
<td>Council was asked to note the report from the GCC’s Approval Panel for the re-approval of the full time and full time equivalent Masters of Chiropractic (MChiro) degree programmes delivered by the McTimoney College of Chiropractic College (MCC) and to agree the recommendation from the Education Committee that Council recognise these as GCC approved programmes.</td>
</tr>
<tr>
<td>Council discussed the reports and information including the levels of assurance provided. Council concluded that sufficient evidence had been provided and, noting the Education Committee’s recommendation to approve the course, agreed the reapproval.</td>
</tr>
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</table>
Agreed: Council agreed the re-approval of the MChiro degree programmes delivered by the MCC.

C1812/12  
**Annual Education Committee report**

SO introduced the annual report which provided Council with an update on the work undertaken by the Committee during 2018.

SO highlighted specific key points from the report:
- That the new programme being taught at London Southbank University (LSBU) had now begun with a new cohort having commenced in September. She said the Committee had also visited the University.
- The Committee had discussed the Test of Competence panel, specifically in regards to panel composition in terms of equality and diversity. It was felt there was room for improvement and agreed that it was important for searches for new panel members to reach and attract the widest audience possible.
- Patient and student involvement would be an area of development in 2019.

Further to the report, Council agreed that it would be good to have more interchange and communication between the Education Committee and Council in relevant areas such as CPD. It was suggested education issues could be a topic for Council learning and development during 2019.

**Action:** TM and SO to consider potential content for a development session at a Council training day.

C1812/13  
**AOB**

There was no other business.

**Date of next meeting:** 26 March 2019
# Actions – December open meeting 2018

<table>
<thead>
<tr>
<th>Item</th>
<th>Actions</th>
<th>Update</th>
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<tbody>
<tr>
<td>C-1812/2</td>
<td>Action outstanding, 1809-05, relating to an analysis of registration numbers, would be completed in the new year after the retention period closed.</td>
<td>Registration report 2018 presented to March 2019 meeting of the Council</td>
</tr>
<tr>
<td>C-1812/4</td>
<td>Action: TM to inform Council of the decision (of whether there would be a pilot of the new standards).</td>
<td>The GCC is taking part in the pilot to be actioned</td>
</tr>
<tr>
<td></td>
<td>Action: Improved information on whistleblowing prescribed person duty to be included on the website by the end of March 2019.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Action: TM to ensure whistleblowing prescribed person duty is communicated and accessible.</td>
<td></td>
</tr>
<tr>
<td>C-1812/5</td>
<td>Action: TM to ensure section 32 work and outcomes are communicated to the profession and stakeholders.</td>
<td>When complete – end April 2019</td>
</tr>
<tr>
<td></td>
<td>Action: NU to ensure learning on advertising cases is shared with the profession following the conclusion of the advertising investigations.</td>
<td>In progress – June Council</td>
</tr>
<tr>
<td></td>
<td>Action: RMD to provide a baseline unit cost for the current FtP process.</td>
<td>completed (see CO-1903-2Bi)</td>
</tr>
<tr>
<td>C-1812/6</td>
<td>Action: NU to further discuss with GOsC and to complete the review of issue 6.39 on the PSA 2017/18 review and action plan and discuss options for change with DHSC by March 2019</td>
<td>Completed. Letter to DHSC</td>
</tr>
<tr>
<td></td>
<td>Action: GCC plan on point 6.38 of the PSA 2017/18 review and action plan to be updated by TM to clarify that interim new process is in place.</td>
<td>Interim arrangements in place</td>
</tr>
<tr>
<td>C-1812/7</td>
<td>Action: TM to identify any baseline data on the range of chiropractors currently involved in work for the GCC and consider further action if necessary.</td>
<td>Not started</td>
</tr>
<tr>
<td>C1812/10</td>
<td>Action: A proposal for final agreement should be brought to the March Council meeting by the Education Committee (regarding the definition of the term 'non practising').</td>
<td>Scheduled for the June Council meeting</td>
</tr>
<tr>
<td>C1812/12</td>
<td>Action: TM and SO to consider potential content for a development session at a Council training day.</td>
<td>completed</td>
</tr>
</tbody>
</table>
To: General Chiropractic Council  
From: Rui Domingues, FD  
Subject: Matter Arising from Dec 2018 – Baseline FtP costs  
Date: 26 March 2019

1. Purpose
This paper provides baseline Fitness to Practice costs, as requested at the December 2018 Council meeting.

2. Background
In the December 2018 Council meeting:
Council discussed the costs of the work and the cost of each case, suggesting that in future there should be a clearer unit cost. Council agreed that it would be useful to see the current baseline unit cost so that we could monitor progress and changes. Discussion took place regarding the benefit that a more right touch investigation process could bring.

3. Action required
Council is asked to note the report.

4. Financial implications
The following baseline costs have been drawn from budgeted 2019 costs for FtP cases.

<table>
<thead>
<tr>
<th>Description</th>
<th>PCC</th>
<th>IC</th>
<th>Advertising</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Per case</td>
<td>Per case</td>
<td>Per case</td>
</tr>
<tr>
<td>Salaries</td>
<td>3,830.56</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NI (Allowances)</td>
<td>356.33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pension</td>
<td>383.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>227.27</td>
<td>500.00</td>
<td></td>
</tr>
<tr>
<td>Allowance</td>
<td>5,500.00</td>
<td>2,200.00</td>
<td>5,500.00</td>
</tr>
<tr>
<td>NI (Allowances)</td>
<td>275.00</td>
<td>110.00</td>
<td>275.00</td>
</tr>
<tr>
<td>Accommodation</td>
<td>960.00</td>
<td>384.00</td>
<td>960.00</td>
</tr>
<tr>
<td>Travel</td>
<td>300.00</td>
<td>600.00</td>
<td>1,500.00</td>
</tr>
<tr>
<td>Expenses</td>
<td>180.00</td>
<td>90.00</td>
<td>225.00</td>
</tr>
<tr>
<td>Catering</td>
<td>120.00</td>
<td>48.00</td>
<td>120.00</td>
</tr>
<tr>
<td>Stenographer</td>
<td>2,000.00</td>
<td>83.33</td>
<td></td>
</tr>
<tr>
<td>Legal Fee</td>
<td>9,000.00</td>
<td>166.67</td>
<td></td>
</tr>
<tr>
<td>Legal Assessor</td>
<td>3,840.00</td>
<td>2,160.00</td>
<td>6,480.00</td>
</tr>
<tr>
<td>Professional fee- expert</td>
<td>5,000.00</td>
<td>6,666.67</td>
<td>2,222.22</td>
</tr>
<tr>
<td>Office costs</td>
<td>45.45</td>
<td>16.67</td>
<td></td>
</tr>
<tr>
<td>Misc (Witness Cost)</td>
<td>454.54</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27,902.27</strong></td>
<td><strong>13,025.34</strong></td>
<td><strong>21,852.11</strong></td>
</tr>
</tbody>
</table>
The actual costs are now monitored on a monthly basis by the Senior Management Team (SMT) as part of the monthly management accounts.

5. **Legal or Risk Implications**
   There are no legal or risk implications arising from this paper.

6. **Equality Implications**
   There are no equality implications arising from this paper.

7. **Communications Implications**
   There are no communications implications arising from this paper.
1. Main focus of the period

The most significant event of the period since the December Council meeting has been the handover of the executive leadership of the GCC. This has been characterised by a strong collaborative spirit between Tricia McGregor and Nick Jones which I have supported through one to one and group meetings. My objective has been to ensure that the momentum for change established in the latter half of 2018 was sustained as the baton was passed from our interim to our new Chief Executive and Registrar. Council members will be able to judge from the agendas for our meetings today whether that has been achieved.

2. Governance matters

Following agreement that Council should carry out an effectiveness review, Steven Gould and I worked together to agree the approach to the review and format for the questionnaire. I much appreciate the full participation of Council in carrying out this review, the outcome of which will be shared in the Training and Development Day. I am particularly grateful for the contributions you have all made to my own performance appraisal. I have already received feedback from this and am working on an action plan.

The annual cycle of Council member appraisals was completed very early in the New Year. It is my intention to draw together any common threads from this and circulate a note in advance of the next phase of appraisals.

In anticipation of Liz Qua’s departure from Council, I have developed the proposals for Council and Committee memberships for the next year which are included on today’s agenda. In parallel, I have been giving consideration to how we can make best use of Council members’ skills and time. I expect this to feed into proposals for some modifications to the way we operate as a Council. If there is a policy change on the matter of regulator governance structures, these proposals would feed into our response to that. If not, then I would want to bring them formally to Council in the first quarter of 2020 as part of a fresh look at our governance.

3. Engagement with the profession

I was invited to speak at the RCC Conference on 30th January. This coincided with 25 years of regulation of chiropractic and was an opportunity to acknowledge the journey travelled since then. I concentrated most of the speech however on the GCC’s current strategy and particularly our desire to work more collaboratively with chiropractors in fulfilling our statutory responsibility to develop the profession. I expressed our hope that the profession would
come together to give leadership for the future. It was good to know that there were Council colleagues in the audience and I am grateful to Gay for her warm introduction.

The 6th February saw the first of the GCC’s meetings with the Professional Associations and the RCC. It was an opportunity to build on a dialogue started by Tricia and to introduce Nick. The mood was positively collaborative and joint work was identified. More information on this is in the CER’s report.

4. Other meetings

The CER and I met with Marc Seale, CEO, and Stephen Cohen, Acting Chair, of HCPC. This meeting enabled us to clarify that HCPC will not be able to offer shared administrative services to us in the short term in the light of their other priorities.

More recently, HCPC announced the appointment of Christine Elliott as their new Chair. I shall be meeting her on the day following the Council meeting.

Mary Chapman
Chair, GCC
1. Summary

This paper sets out some proposed changes to arrangements for GCC Governance from April 2019. It has been written in the light of the upcoming departure of Liz Qua and following email consultation with Council members. It seeks approval from Council for retaining a Council of 12 members, leaving vacant one lay and one registrant position. It seeks approval for a new appointment to the Education Committee and notifies Council of a Chair’s appointment to the Audit Committee.

2. Council Membership

The composition of the governing Councils of the health and care professions regulatory bodies is currently under review as part of the Department of Health and Social Care’s consultation on the future of regulation. While the Department’s response is still awaited, it is possible that there will be changes to policy on this matter. The GCC needs to bear in mind that options under consideration include the creation of new unitary boards, the reduction of the maximum size of boards to 12 and different requirements in terms of the skills mix and experience of board members. Linked to this might be a review of the way the regulators fulfill their four nation responsibilities.

Last year the Privy Council, with the advice of the PSA, agreed that it was acceptable for the GCC to hold vacancies against its maximum complement of 14 Council members, provided that it was able to discharge its statutory responsibilities, operate its committee structures effectively and retain a broad balance of lay and registrant members. On Liz’s departure, Council numbers will fall to 12, split equally between lay and registrant members. It is proposed that, in the light of the potential changes to the regulatory framework, we should not seek to fill the vacancy. I am confident that Council will be able to manage its business effectively with twelve members.

This decision would leave us better placed to respond to any upcoming policy changes which might emerge from the consultation. It is also consistent with our strategy to streamline our operations and build a more sustainable model for the future. While the saving to governance costs is not dramatic, it will make a contribution to achieving breakeven in a timely fashion.

It is proposed that Council review this decision once the outcome of the DoHSC consultation is known and in any event within 18 months.
3. Four nation responsibilities

To ensure that Council is able to fulfill its responsibilities to all four nations, it is proposed the Ralph Pottie should take on the role of Northern Ireland representative in addition to the one he holds currently for Scotland. Ralph has good contacts in Northern Ireland and has indicated that he is prepared to accept the role.

4. Education Committee membership

Appointments of Council members to the Education Committee, as a statutory committee, are to be determined by Council, following a process which includes nomination and if necessary election.

The Committee has a demanding agenda over the next few years with the prospect of new educational institutions and programmes coming forward for approval and the oversight of new arrangements for CPD. It faces particular challenges posed by the size of the chiropractic profession as members wear a number of hats and may have to stand back from decisions where they have a conflict of interest. There is a risk that too few competent people are then available to provide proper scrutiny to decisions.

The Committee Chair has indicated a preference for a registrant member of Council to fill the upcoming vacancy. It is important to strengthen the committee’s membership with people who bring a good understanding of the clinical and educational issues. She has proposed that Ralph Pottie should be appointed. Ralph, as a relatively recent registrant member, has not yet taken up a committee position and has indicated that he is ready to commit to this role. He would also bring with him knowledge of the rather different Scottish educational context. In correspondence, members of Council have indicated that they are content with this proposal and have made no alternative nominations.

5. Audit Committee

Appointments to non-statutory committees are to be determined by the Chair.

The upcoming vacancy leaves the Audit Committee with 2 registrant and one lay member. As the committee’s responsibilities extend beyond financial audit matters to risk and wider governance issues it seems important to have an equal balance of lay and registrant members. I am planning to appoint Keith Richards, who will bring extensive governance experience in non-executive roles in a range of contexts to complement to the skills of the other committee members. Keith has yet to serve on a committee of Council and has indicated that he is prepared to accept this appointment.

6. Council members are asked to:

- Approve the proposal to retain Council membership at 12 people, to be reviewed at the latest by September 2020.
- Approve the proposal that Ralph Pottie should be named as the representative with responsibility for Northern Ireland.
- Approve the appointment of Ralph Pottie to the Education Committee.
- Note the appointment of Keith Richards to the Audit Committee.

Mary Chapman
Chair, GCC
Purpose

Council is asked to note the contents of the report.

Introduction

This report summarises key developments in the period since the Council last met.

1. The GCC team

I joined the GCC on 18 February 2019 and have been warmly welcomed by the team, all of whom have been helpful and supportive. I benefited from a very comprehensive ‘handover’ by Tricia McGregor, interim Chief Executive and Registrar who departed the GCC with our gratitude and best wishes, and my personal thanks for her commitment to my positive start.

I am pleased to have inherited a business plan for the year that takes forward our transformation to meet our strategic goals agreed at the December 2018 meeting of the Council.

As is the case in all new roles I have combined induction with dealing with operational and stakeholder matters, many of which are detailed below.

2. Professional Standards Authority

2.1 Annual performance review

I have received a letter informing me that our annual performance review undertaken by the PSA has now started. It is initially a desk-based exercise with a recommendation made to the panel in late April 2019. The progression of the review then depends on the recommendation made to the panel and its decision. If it is that standards are met we can expect publication in late July 2019. If the panel decide that a targeted review is required, then the time for the publication of the performance review report is likely to be September 2019. If the panel decide that an audit is also required then the publication will be towards the end of the year.

I took the opportunity to meet with colleagues from the PSA, including our senior scrutiny officer leading the review who very helpfully took me through the process such that I am now across it.

Progress with regards to meeting the actions outstanding from our review in 2018 are annexed to this report.
2.2 Standards of Good of Regulation (SGR)

Three members of the GCC team attended an SGR evidence framework workshop led by the PSA. This has helped us gain further understanding on how the new standards might be met and will inform our work towards meeting the new standards. Following the workshop the PSA contacted all regulators to ask for expressions of interest in taking part of a pilot of the new standards. The pilot would take place during 2019 and the results would not be published, rather they would be used by the PSA and the regulator to inform the use of the standards going forwards. The new standards will be used fully for reviews taking place in 2020 for the 19/20 review period. We have concluded that taking part in the pilot would be beneficial in terms of early sight on areas of development and we have therefore indicated we will take part. The details and timing of the pilot are still to be confirmed and the PSA has indicated it will work with regulators to agree timings that will minimise disruption to the delivery of regulators’ operational priorities.

2.3 Duty of Candour

The PSA’s report ‘Telling patients the truth when something goes wrong: Evaluating the progress of professional regulators in embedding professionals’ duty to be candid to patients’ (annexed) was published on 21st January 2019.

Telling patients openly and honestly that something has gone wrong with their care is an essential part of a healthcare professional’s practice. Inquiries and investigations indicate that health professionals have failed to tell the truth when a patient has been harmed, whether by withholding or misrepresenting the facts. The report explored how UK professional regulators have attempted to encourage healthcare professionals to be open and transparent when something has gone wrong in the care they or someone else have provided.

Our Code states at B7: [You must] Fulfil the duty of candour by being open and honest with every patient. You must inform the patient if something goes wrong with their care which causes, or has the potential to cause, harm or distress. You must offer an apology, a suitable remedy or support, along with an explanation as to what has happened.

We also published guidance on candour published in 2016, to be viewed alongside the requirements set out in the Code. The annual review of fitness to practice (elsewhere on the agenda) suggests that there is more to do.

2.4 International Registrants

The PSA wrote to us in December 2018 after it emerged that a consultant psychiatrist worked for many years on the basis of fake qualifications. The Authority published a report of its rapid review of the current practise of regulators indicating all appeared to have appropriate processes. However the review was desk-based. Consequently, the PSA asked each regulator to indicate if their own processes for checking the veracity of registrants’ qualifications were robust. It also asked whether regulators’ historical processes had vulnerabilities and, further, whether, on that basis, the re-checking of the qualifications of
registrants might be a proportionate step. We considered this carefully and confirmed the robustness of our processes and that, in our view, a retrospective checking process was unnecessary.

2.5 European Union exit

The PSA wrote to the GCC in January asking us to tell it of any particular concerns we have regarding a 'no deal' EU exit. Our response is informed by the small numbers of EU applications to our register (and the option to sit the Test of Competence). Moreover EU exit does not, in our view, give rise to business continuity issues within the GCC or profession and, as such, the risks are low. On this basis we confirmed that the GCC has no serious concerns regarding a no deal EU exit.

2.6 Fitness to Practise Chairs’ Conference

The PSA is holding a conference on 25th March with places available for panel chairs, members or legal assessors as well as regulators’ staff. Three of our Chairs will be attending the event.

2.7 PSA Academic and Research Conference 7/8th March

I attended the conference entitled ‘What is it to be a good regulator?’ This was a good opportunity to meet senior colleagues from other professional regulatory bodies, the Department for Health and Social Care as well as hearing about policy and research developments within professional regulation.

There were many useful and diverse sessions covering topics such as regulating sensitively in a sometimes insensitive regime; shifting the balance of activity to support the profession to develop and improve, at the same time as talking appropriate action in protecting the public; and creating an environment where professionals have a trusted process where they can demonstrate their development endeavours that reflects what they actually do in that regard – what we might call ‘CPD’ which somehow loses the essence of what we are all collectively trying to achieve.

It is clear that some of our colleagues make a substantial investment in research and policy which we cannot or should not match – but we can stay close to the work and strike up partnerships where it is helpful for us to do so – for example as with the General Osteopathic Council in our joint research, and dissemination activity, on ‘touch.’
3. The Department of Health and Social Care (DHSC)

3.1 Regulatory reform

The Department of Health (as it then was) consulted in October 2017 on major reform to the professional regulation landscape: Promoting professionalism, reforming regulation. The proposed model of professional regulation is designed to secure public trust; improve clinical practice; and adapt to developments in healthcare. Government has yet to formally respond to the consultation with next steps – in part due to the political environment. That said there has continued to be discussions between DHSC colleagues and fellow regulators – for example in thinking about possible operational frameworks, relating to governance arrangements, for example ideas include, rationalizing the size of boards to better fit current best practice in board size and composition.

Our efforts here are helped in that there is substantial congruence between our expectations for positive change and those of the other bodies.

3.2 Removing the limits on the size of Fitness to Practise (FtP) panels

DHSC has informed us that it is proposing ‘minor’ amendment to legislation (also affecting the General Optical Council and General Osteopathic Council) to remove the limit of members for their Fitness to Practise (FtP) committees. In any event, such a change will be picked up in the major reform programme; the proposed change here is ‘a quick solution’ to stop the potential bottleneck of FtP cases not reaching a conclusion due to the limiting maximum number for the committees. The legislative change would be small, for example “The membership of the Committee shall consist of the registered chiropractors and lay persons included in the list of no more less than 30 persons maintained by the General Council of persons appointed to the Committee”. We indicated our support for the proposal, which, if taken forward will be implemented in July 2019 at the earliest.

3.3 Appropriate clinical negligence cover

The GCC responded to a consultation conducted by the Department of Health and Social Care (DHSC) on clinical negligence cover for health care professionals. The consultation questioned whether using indemnity arrangements other than through insurance is adequate since registrants have, on occasion, been refused when making claims leaving them financially liable. The DHSC proposed the following options, although state that option 2 is preferred:

- Option 1: Maintaining the existing legislation and arrangements related to clinical negligence cover, i.e., ‘do nothing’
- Option 2: Legislative change by way of secondary legislation to ensure that regulated healthcare professionals in the UK (not covered by a state-backed scheme) hold appropriate clinical negligence cover that is subject to appropriate supervision by the Financial Conduct Authority (FCA) and Prudential Regulation Authority (PRA).

The changes proposed by DHSC have little or no impact on GCC registrants holding indemnity through an insurance company, whose schemes are already protected by the
FCA. However, we recognise this is not the case across all health-care regulators and therefore have no issue with the introduction of government’s preferred option.

4. **Home Office consultation on preventing and tackling forced marriage**

This consultation sought views about whether it is necessary to introduce a new legal mandatory reporting duty relating to cases of forced marriage and, if it is, what such a reporting requirement would look like. It also sought views on how the current guidance on forced marriage could be improved and strengthened. We responded that if a reporting duty for forced marriage was introduced, that it should apply to regulated health professionals.

5. **Engagement with the professional bodies**

On 6 February 2019 we met with colleagues from:

- Royal College of Chiropractors (President and Chief Executive)
- The British Chiropractic Association (President)
- United Chiropractic Association (Chief Executive and President)
- McTimoney Chiropractic Association (Chief Executive)
- Scottish Chiropractic Association (President)

This was the latest meeting with the professional bodies with a view to establishing effective working relationships and developing the profession. We discussed a common definition of chiropractic and made good progress. We also covered how the associations and the college might develop a collaborative relationship – enabling effective engagement with the GCC on a range of fronts – notably some joint projects around promoting a clear expression of the evidence underpinning practice; promotion of the I am a Chiropractor scheme, and so on. We aim to meet approximately three times per year. Progress with taking that work forward is captured within the business plan priorities reported elsewhere in the meeting.

6. **Test of Competence (TOC)**

The results from the two ToC sessions in 2019 are:

<table>
<thead>
<tr>
<th>January 2019</th>
<th>March 2019</th>
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<tr>
<td>Two passes</td>
<td>Two passes</td>
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<tr>
<td>Two Insufficient Evidence (both went onto pass)</td>
<td>Two Insufficient Evidence</td>
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The next TOC interviews will be held on 20th June, and 19th September 2019.

7. **Education programme**

We continue to work with the emerging educational programme in Scotland, and the pending application from Teesside University. We met with the team from Teesside on 12 December 2018. A further ‘virtual’ meeting of the Education Committee was held with Teesside on 8 January 2019 to consider the business case. Both meetings took place on the basis that Teesside was committed to a course start date of September 2019. Whilst
ambitious we worked hard to facilitate this within what looked like being a very tight timescale, and are grateful to partners involved in the assessment process for their flexibility. In any event, we have subsequently been advised that a launch date in September 2020 is now favoured by the Teesside team. As such, we continue to work with the team in facilitating a smooth as possible process.

8. Conferences and meetings

- On 25 February I met with the Chief Executive and Registrar of the General Osteopathic Council, Tim Walker. Given he was retiring within a week or two it was a great opportunity to discuss his experiences as CER and other issues of mutual interest. I will be meeting with the incoming CER, Leonie Milliner shortly.

- On Saturday 9 March 2019 I attended the United Chiropractic Association Spring Conference with the Registration Manager. We were welcomed warmly; I was invited to speak from the platform for 15 minutes which was a good opportunity to convey our ambition; and we received feedback on our work and our presence – much of which was positive and in any event helpful.

- On 14 March I attended, with the GCC Educational Officer, the McTimoney College of Chiropractic in Abingdon and met with Professor Christina Cunliffe, Principal. It was a very productive and interesting day. My plan is to visit the other colleges over time.

- I attended the International Chiropractic Regulatory Society annual meeting in Berlin and the World Federation of Chiropractic and the European Chiropractors’ Union (EPIC) conference on 20/21 March 2019. I will provide oral feedback at the meeting.

9. Draft guidance for health professionals acting as expert or professional witnesses

In 2018, Sir Norman Williams’ review of the use of gross negligence manslaughter (GNM) in healthcare commissioned by the Secretary of State for Health and Social Care following the Bawa-Garba case recommended steps on improving assurance and consistency in the use of experts in GNM cases (Recommendation 2). This called on “The Academy of Royal Medical Colleges, working with professional regulators, healthcare professional bodies and other relevant parties, should lead work to promote and deliver high standards and training for healthcare professionals providing an expert opinion or appearing as expert witnesses. These standards should set out what, in the Academy’s opinion, constitutes appropriate clinical experience expected of healthcare professionals operating in such roles.”

Draft guidance was developed and shared with us, of which we are supportive. When finalised I will share with Council and also ensure it is shared with expert witnesses wherever possible. It will also be brought to the attention of the professional associations.

Nick Jones
CER
March 2019
## Guidance & Standards

<table>
<thead>
<tr>
<th>Standard from PSA report</th>
<th>Comment/ Action from report</th>
<th>GCC Plan</th>
<th>Person responsible</th>
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<tbody>
<tr>
<td>Standard 4: The standards and guidance are published in accessible formats. Registrants, potential registrants, employers, patients, service users and members of the public are able to find the standards and guidance published by the regulator and can find out about the action that can be taken if the standards and guidance are not followed.</td>
<td>3.7 As part of its 2017 communication activities, the GCC said it would continue to work closely with the other healthcare regulators, the Welsh Government and the Welsh Language Commissioner to enhance the support that the GCC provides to people who wish to engage with it in Welsh.</td>
<td>We continue to work with others but await a decision from the Welsh Government as to their requirements of healthcare regulators. Time line to be confirmed after follow up with Welsh Government by Jan '19. <strong>Update March 2019:</strong> The Welsh Government is developing a new bill to redirect resources to ensure growth in the number of people to speak Welsh rather than concentrating a significant proportion of the Welsh language budget on making and policing the standards. We continue to fulfil our statutory duties but it is unlikely new standards for other sectors will be introduced. The Bill has not been published. We will liaise closely with standards when the Bill is published.</td>
<td>Penny Bance</td>
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## Education & Training

<p>| Standard 1: Standards for education and training are linked to standards for registrants. They prioritise patient and service user safety and patient and service user centred care. The process for reviewing or developing standards for education and training should incorporate the views and experiences of key stakeholders, external events and the learning from the quality assurance process. | 4.4 Last year, the GCC commissioned research to find out whether graduates were as prepared as they could be to treat patients, and what could be done to help graduates be more prepared. 4.5 A series of recommendations were made. These included: • to increase the number of work placements, mentoring and role-playing opportunities by which graduates could further develop vital communication skills • to ensure that the education course content sufficiently covered key patient-centred skills including those areas identified as weakest in newly-qualified practitioners: when and how to make referrals; developing and documenting a plan of care; and legislation relating to chiropractic care • to widen opportunities for and encourage greater take-up amongst newly qualified practitioners of mentoring, shadowing and other forms of development to broaden experience. 4.6 We will monitor how the GCC uses the findings of this research. | Work commenced in 2018 with publication, dissemination and discussions. Actions are now incorporated into the GCC 2019 business plan - there is a specific objective 'facilitate agreement on a plan of to enable the profession/ chiropractors to better support newly qualified chiropractors by December 2019'. | Penny Bance |</p>
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<tr>
<th>Area of review</th>
<th>Standard from PSA report</th>
<th>Comment/ Action from report</th>
<th>GCC Plan</th>
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<td>Registration</td>
<td>Standard 3: Through the regulator’s registers, everyone can easily access information about registrants, except in relation to their health, including whether there are restrictions on their practice.</td>
<td>The published register It is not clear why the GCC did not decide to update its online search function to include the information required by its legislation.</td>
<td>We agree that the online search function should be the GCC's online register in terms of the Act. This requires an amendment to be made to the online search function to include the addresses of non practising registrants. The service provider is unable to complete this work. The Act requires that the ‘published list’ is published annually before the anniversary of the opening of the register (15 June). We are planning an upgrade to our registrations database which would resolve the register issues and be complaint with the Act. This will be in progress by then, and may have been concluded. <strong>Update March 2019:</strong> It is unlikely this work will be completed by June 2019. As such we are exploring if changes can be made to sign-posting to make clearer whether there are restrictions on a registrant's ability to practise.</td>
<td>Penny Bance</td>
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<td>Standard 6: Through the regulator’s continuing professional development/revalidation systems, registrants maintain the standards required to stay fit to practise.</td>
<td>5.20 A public consultation on the new scheme, however, remains scheduled for 2018, and it is still anticipated that the new CPD scheme would be implemented in 2019. We will continue to monitor this area and report on developments in next year’s review report.</td>
<td>Ensure CPD business process review/changes are documented in public papers so that we can demonstrate progress. The GCC's business plan 2019 has a specific objective to 'Develop and implement a proportionate approach to CPD submissions and audit by September 2019.' <strong>Update March 2019:</strong> In line with the 2019 Business Plan progress is expected to be reported to the June 2019 meeting of the Council. We will provide PSA with draft in advance</td>
<td>Penny Bance</td>
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<td>Area of review</td>
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<td>Fitness to Practise</td>
<td>Standard 2: Information about fitness to practise concerns is shared by the regulator with employers/local arbitrators, system and other professional regulators within the relevant legal frameworks.</td>
<td>6.5 In August 2017 the Care Quality Commission (the CQC) shared a revised draft information sharing agreement with the GCC after the latter had fed back comments on the previous version. A final version of the agreement is not yet publicly available. Although we note the delay to finalising the agreement, we have not identified any risk to public protection.</td>
<td>Follow up with the CQC and finalise the agreement by March 2019. <strong>Update March 2019:</strong> The agreement is expected to be confirmed by the CQC prior to the end of March 2019. An update will be provided to the March 2019 meeting of the Council.</td>
<td>Penny Bance</td>
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<td>Standard 4: All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel.</td>
<td>6.15 The GCC’s process primarily focuses on whether the risk in a case meets the threshold for referral to an interim order hearing. We consider that whilst a case may not meet the high threshold for referral for an interim order hearing, it may still present risk and require prioritisation, and therefore an analysis of risk beyond whether the case requires referral for an interim order hearing is required.</td>
<td>Include in business process review and amend processes as required by August 2019. NU to add to list of matters to be raised with GOsC at visit on 14/11/18. <strong>Update March 2019:</strong> This work is progressing and proposals will be made to the June 2019 meeting of the Council</td>
<td>Niru Uddin</td>
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<td>6.16 In response to our feedback, the GCC confirmed that it does not carry out risk ratings of cases. It stated that the GCC’s business plan for 2018/19 includes a wider review of FtP processes and as part of this, the GCC will consider whether and how other regulators use risk rating and whether the GCC should implement a similar process.</td>
<td>Include in business process review and amend processes as required by August 2019. NU to add to list of matters to be raised with GOsC at visit on 14/11/18. <strong>Update March 2019:</strong> This work is progressing and proposals will be made to the June 2019 meeting of the Council</td>
<td>Niru Uddin</td>
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<td>Standard 6: Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients and service users. Where necessary the regulator protects the public by means of interim orders.</td>
<td>6.28 We concluded that although there were delays present in the advertising cases we audited, our audit did not identify widespread concerns about timeliness. We note that the median timeframes provided by the GCC have fluctuated, but at this time do not consider that this is an indication of a decline in performance. We will monitor the GCC’s progress with its advertising caseload over the next performance review period as well as the relevant data about its wider fitness to practise caseload.</td>
<td><strong>Update March 2019:</strong> See March 2019 performance report to Council. 225 cases have now been closed with no case to answer. There are 68 cases remaining which will be considered at the final three weeks of IC meetings. In the event that there are cases outstanding (adjournments) after the three weeks, we have taken the step of scheduling now six days of meetings for May 2019. All being well we are looking for this exercise to conclude in May 2019, at the conclusion of these cases.</td>
<td>Niru Uddin</td>
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<td>Fitness to Practise</td>
<td>Standard 8: All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession.</td>
<td>6.37 The GCC had now identified 27 such matters, of which eight had been passed over to its fitness to practise team to progress to the IC. A further seven matters were under ongoing review, as the information held on the registration file was insufficient to confirm whether the matters involved require referral to the IC, while the remaining 12 matters had been handed to the fitness to practise team.</td>
<td>Conclude the action plan by Jan ’19. All cases now resolved apart from one which is pending arrival of a DBS check. A final letter has been sent to the registrant with a deadline for the DBS check to be dealt with before the file is passed to FtP for action if there is no response. <strong>Update March 2019: Completed</strong></td>
<td>Penny Bance</td>
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<td>6.38 It is concerning that the GCC failed to follow the legislation which provides its powers when determining the outcome of several cases involving convictions. However, the GCC has so far taken reasonable steps to remedy the situation and we will continue to monitor its actions in ensuring that those cases which are required by law to be referred to the IC are properly considered.</td>
<td>Business process review to include revised processes and protocols for handling these cases by August 2019. In the meantime, amended processes are in place.</td>
<td>Penny Bance</td>
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<td>6.39 An issue with the GCC's primary legislation, the Act, has been identified - the Act does not allow for a final PCC to impose an interim order of conditions, meaning that a registrant subject to a substantive sanction of conditions, can practise without restriction until the end of the 28-day appeal window, or if an appeal is made, until the appeal is resolved. 6.41 We note that the imposition of conditions appears to be a rare occurrence among GCC cases, but we consider that this issue arising from the GCC’s legislation, with which it is required to comply, has the potential to put the public at risk of harm. The GCC may wish to consider raising this with Government.</td>
<td>Discussed with DHSC in Jan ’19 and the GCC is preparing a briefing paper for the DHSC to be submitted by March 2019. <strong>Update March 2019: The CER wrote to DHSC following receipt of legal advice on 19 March 2019 requesting consideration be given to this matter.</strong></td>
<td>Niru Uddin</td>
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Telling patients the truth when something goes wrong
Evaluating the progress of professional regulators in embedding professionals’ duty to be candid to patients

January 2019
About the Professional Standards Authority

The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators’ performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

To encourage improvement we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation.¹ We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and care workforce.

We are committed to being independent, impartial, fair, accessible and consistent. More information about our work and the approach we take is available at www.professionalstandards.org.uk.

¹ The Professional Standards Authority (2015). Right-touch regulation – revised
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1. Background

1.1 Telling patients openly and honestly that something has gone wrong with their care is an essential part of a healthcare professional’s practice. The obligation to do so is known as the professional duty of candour. It can be difficult for professionals to do for a variety of reasons, but they are expected to be candid by the public and regulators. Inquiries and investigations over the years have found evidence that health professionals have failed to tell the truth when a patient has been harmed, whether by withholding or misrepresenting the facts.

1.2 This paper explores how UK professional regulators have attempted to encourage healthcare professionals to be open and transparent when something has gone wrong in the care they or someone else have provided. This is known as the professional duty of candour. The paper looks at what progress has been made since 2014 when the regulators published their joint statement on candour encouraging their registrants to be candid; and in enforcing the professional duty of candour through fitness to practise processes.²

1.3 Issues of openness, transparency and candour were prominent in 2013 in the aftermath of the publication of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Report).³ Patients and their relatives fought for a long time to find out the truth about their care. These issues are still pertinent now, as evidenced in the Hyponatraemia Inquiry of Northern Ireland, which focused on the deaths of five children. Among its findings, the report found that there was ‘repeated lack of honesty and openness with the families’ of the children.⁴

1.4 In 2014 in response to the Francis inquiry report, the Government published Hard Truths.⁵ In that report, the Government stated that it was introducing a statutory duty of candour on all Care Quality Commission (CQC) registered providers in England, making it a requirement for them to be open and honest where there have been failings in care. It was introduced in England in 2014. A duty came into force in Scotland in April 2018. It is currently being consulted on in Wales and has been called for in Northern Ireland in the wake of the Hyponatraemia Inquiry.

1.5 Hard Truths also made clear that issues of candour were applicable to professionals as well as to organisations. The Government noted that it was working with professional regulators to strengthen references to candour in professional regulation and professional regulators would be working to agree consistent approaches to candour and reporting of errors. In 2013, the Government asked the Professionals Standards Authority to advise and report on regulators’ progress in encouraging candour.⁶

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² Joint statement from the Chief Executives of statutory regulators of healthcare professionals (2014).
⁶ Professional Standards Authority (2013). Can professional regulation do more to encourage professionals to be candid when healthcare or social work goes wrong? Advice to the Secretary of State.
1.6 The nine regulators we oversee established a working group to develop a consistent approach to candour. They developed a joint statement on the professional duty of candour, which was signed by eight of the regulators. They also committed to review standards where necessary, encourage registrants to reflect on the duty, and other initiatives. In 2014, we commended the regulators on their commitment to developing a common approach.\(^7\) We did emphasise though that there was more work to be done to fully embed a common approach to candour.

1.7 After this, many regulators worked to encourage their registrants to behave candidly through various means like updating standards, developing guidance and altering fitness to practise guidance. Since our report to the Secretary of State on the progress of the regulators, we have commented in responses and performance reviews about the approaches of individual regulators and governments to candour. We now want to look at the progress of the regulators in embedding candour and how candour can be further encouraged in professionals. Another reason for this paper is that, despite the joint statement by regulators, we have subsequently seen little reference being made to the duty of candour in the allegations being brought by any of the regulators, or in the determinations of fitness to practise panels.

1.8 This paper is also a chance to revisit conclusions we have previously made in our analysis of barriers to professionals being candid and understand if there are new barriers and whether previously identified barriers remain.\(^8\)

1.9 To understand reasons in paragraph 1.7 and delve into detail about the barriers to candour, we created questionnaires and sent them to stakeholders across health and social care, as well as posting a call for information questionnaire on our website, which was open to organisations and individuals to respond to. We then hosted discussion groups with staff from regulators and fitness to practise\(^9\) panellists, which were facilitated by Annie Sorbie, Lecturer in Medical Law and Ethics at the University of Edinburgh.

1.10 This paper is focused on the candour of professionals to those in their care and their families when a mistake has been made. It does not look at whistleblowing, which is when an individual reports workplace concerns about unsafe care or wrongdoing. However, there is an overlap between the two and they are both affected by similar factors, so there may be learning from this paper for whistleblowing.

1.11 We recognise though that the workplace culture in which a professional practises can influence professionals’ candour towards patients: working in an environment that prizes openness is more conducive to professionals being open and honest

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\(^7\) Professional Standards Authority (2014). *Progress on strengthening professional regulation’s approach to candour and error reporting: Advice to the Secretary of State.*

\(^8\) Professional Standards Authority (2013). *Candour, disclosure and openness Learning from academic research to support advice to the Secretary of State.*

\(^9\) Fitness to practise is a process in which a regulator will investigate a concern raised by an employer, the public, practitioner or other body about a registrant. In order to protect the public, the regulator may issue sanctions ranging from warning a registrant to erasing them from the register.
with patients. We bring attention to this factor when discussing barriers to candour in chapter 4.
2. Methodology

2.1 We first carried out desk research to collect data for the project. The findings of the desk research shaped the questionnaires we sent to different organisations and the priorities we set for the facilitator of the discussion groups. Most of the evidence used in this paper was collected by tailored questionnaires sent to regulators and other organisations across health and social care and a call for evidence on our website asking organisations and individuals to respond, and discussion groups with staff members and fitness to practise panellists of regulators.

Desk research

2.2 We reviewed thoroughly the regulators’ documents to understand where candour featured in their practices. We also revisited our past findings on candour and the recommendations we made to the Secretary of State. We followed the discussions around candour in contemporary events like the Hyponatraemia Inquiry and the debate around the Health Service Safety Investigations Bill. We analysed reports by authors and organisations beyond regulation on issues relating to candour such as the Royal College of Surgeons review by Sir David Dalton and Professor Norman Williams on proposals to enhance candour.

Questionnaires

2.3 We created questionnaires that were tailored to different types of stakeholder in the health and care sector. These were split into the following types: professional regulator, education provider, legal and professional/representative organisation. For organisations that did not fit into those categories, we sent a less specific questionnaire. We chose a variety of stakeholders across the sector to contact because our previous work on barriers to candour had found that there was a range of factors which affected the candour of professionals. This variety of stakeholders across health and care helped to give non-regulatory perspectives on candour and a chance of situating the extent of regulation’s role in influencing candour.

2.4 There was overlap in the questions of all the questionnaire types. For example, all questionnaires included the question: ‘Do you think there has been a change in professionals’ attitudes to candour since 2014? (the regulators’ joint statement was published in 2014) If so, how?’. The shortest questionnaire was six questions, whilst the longest questionnaire was 13 questions. We received responses from 30 organisations, in addition to the nine regulators we oversee.

2.5 We posted a call for information on our website, which included a shortened questionnaire of six questions that overlapped with many on the bespoke questionnaires described above. This gave an opportunity for organisations we had not contacted to contribute information to this paper. We received responses from 10 organisations.

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10 See our evidence to the Joint Committee on the Draft Health Service Safety Investigations Bill.
11 Sir David Dalton, and Professor Norman Williams (2014) Building a culture of candour, Royal College of Surgeons.
2.6 The call for information also invited individuals to contribute. They were asked to complete the same questions as organisations in the call for information. We received responses from 11 individuals. Most were health and care practitioners.

Discussion groups

2.7 To better understand issues of candour related to fitness to practise, the Authority hosted discussion groups with people involved with fitness to practise at different regulators. While recognising the limitations of this method, the groups were an opportunity to listen to different perspectives on themes from the questionnaire responses and to explore any notable points that were absent from many questionnaire responses, for example the role of the public in candour. The discussions were facilitated by Annie Sorbie, Lecturer in Medical Law and Ethics at the University of Edinburgh. Annie added a critical eye to the findings, drawing them together and identifying themes, which she then relayed to the Authority.

2.8 There were two discussion groups, which convened on consecutive days. No participant took part in both groups. The groups were organised around the following participant types:

<table>
<thead>
<tr>
<th>Discussion group one</th>
<th>A discussion between regulatory staff who help with triage, investigation and fitness to practise matters</th>
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<tbody>
<tr>
<td>Discussion group two</td>
<td>A discussion between case examiners, investigation panel members and fitness to practise panel members</td>
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2.9 There were six participants in the first group and seven in the second group. All regulators, except one, were represented at one or both of the discussion groups.

2.10 All information provided by discussion group participants has been treated in confidence: participants’ contributions will not be attributed individually or to their respective regulators. The conduct of the discussion groups was approved by the University of Edinburgh’s Research and Ethics Committee.
3. Understanding and measuring candour

3.1 Earlier, this paper outlined candour as a professional being ‘open and transparent when something has gone wrong’ in care for a person. A more comprehensive definition of candour is the one listed in the joint statement by regulators.

**The professional duty of candour**

Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress. This means that healthcare professionals must:

- tell the patient (or, where appropriate, the patient’s advocate, carer or family) when something has gone wrong;
- apologise to the patient (or, where appropriate, the patient’s advocate, carer or family);
- offer an appropriate remedy or support to put matters right (if possible); and
- explain fully to the patient (or, where appropriate, the patient’s advocate, carer or family) the short and long-term effects of what has happened.

Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns.\(^{12}\)

*Figure 1: Joint statement by the regulators on the Professional Duty of Candour*

3.2 We used the regulators’ joint definition of candour in all questionnaires and information sheets to prepare participants for the discussion groups. This will be the longer working definition of what we mean by candour of professionals in this paper. As mentioned earlier, this paper will focus on professionals’ candour towards patients and not on professionals’ candour to other colleagues, employers and relevant organisations. However, this paper does touch on these topics a few times as they are often intertwined. For instance, it was pointed out by one discussion group participant that when something has gone wrong, it is not just patients who are informed but also other professionals and senior managers. The result of this is that there are inter-professional considerations when a professional is making a candid admission in the event of an error.

3.3 Some stakeholders in our 2013 candour work highlighted that ‘the words candour or candid…are not widely understood words and/or mean very different things to different people’.\(^{13}\) This has been echoed again in this report where one regulator noted that the term candour is a ‘difficult one’, which it had to debate with its

\(^{12}\) [Joint statement from the Chief Executives of statutory regulators of healthcare professionals](https://www.royalcolleges.ac.uk) (2014).

\(^{13}\) [Professional Standards Authority](https://www.professionalstandards.org.uk) (2013). *Can professional regulation do more to encourage professionals to be candid when healthcare or social work goes wrong? Advice to the Secretary of State* p40.
registrants over using implicitly or explicitly in their code. One professional body relayed that some of its members suggested the duty could be better explained using more ‘everyday language’ than the duty of candour. Additionally, a few respondents noted that professionals have had a duty to be candid for many years, with one organisation suggesting that professionals view the professional duty of candour as a ‘repackaging and relabelling’ of a normal professional responsibility.

3.4 Awareness of the need to be candid amongst professionals is not just shaped by the duty of candour definition on the previous page. One stakeholder noted that ‘significantly higher’ awareness of candour since 2014 was not just down to the duty of candour but also as a result of high-profile healthcare issues in the media such as the Montgomery case, where informed consent of a patient was the focus.14 However, the public’s awareness of the duty of candour is debatable, with discussion group participants suggesting to us that the public rarely mention the duty of candour.

3.5 Awareness of candour has been tempered by confusion over the types of candour. As mentioned in the background to this paper, there are two duties of candour: statutory (or organisational) and professional. The former refers to the organisational duty for healthcare provider organisations to be open and honest with patients and families. A few respondents to the questionnaires noted that there was overlap between the two duties and that this was sometimes confusing, or even frustrating, for professionals. Additionally, a stakeholder observed that the ‘conflation’ between the two duties of candour can sometimes be counter-productive and not helpful for patients in the event of a notifiable safety incident15 being triggered where it should not. The stakeholder described that the professional duty of candour is a ‘common sense principle’ for the relationship between professional and patient where the professional is expected to explain all the steps of treatment to a patient throughout their entire time of care. This could be reaffirmed and strengthened, but not replaced by a ‘bureaucratic, Trust-led process’. This example shows that a candid atmosphere should prevail in all circumstances of care and that there are limitations to this being enforced by ‘bureaucratic’ mechanisms of healthcare providers.

3.6 Another stakeholder suggested it could be helpful if the professional duty ‘when something goes wrong’ threshold could be incorporated as a new level within the

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14 Montgomery (Appellant) v Lanarkshire Health Board (Respondent) [2015]

15 A notifiable safety incident means: ‘any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a healthcare professional— (a) appears to have resulted in— (i.) the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user’s illness or underlying condition, (ii.) an impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days, (iii.) changes to the structure of the service user’s body, (iv.) the service user experiencing prolonged pain or prolonged psychological harm, or (v.) the shortening of the life expectancy of the service user; or (b) requires treatment by a healthcare professional in order to prevent— (i.) the death of the service user, or (ii.) any injury to the serviceuser which, if left untreated, would lead to one or more of the outcomes mentioned in subparagraph (a).’ This definition comes from the CQC’s Regulation 20: Duty of Candour.
organisational duty of candour so that health professionals and administrators can work to one streamlined system.

3.7 On comparing the two duties, one organisation concluded that the organisational duty of candour is more useful for professionals as it sets out how serious the harm has to be before the duty of candour process must be initiated. More details can be found in paragraph 5.10.

3.8 It is also of note that the professional duty of candour not only overlaps with the organisational duty of candour, but also with the NHS complaints process where there is a requirement on public bodies to be open and honest when accounting for decisions and actions and the need to explain fully when things have gone wrong and how they can ‘put matters right as quickly as possible’. One stakeholder suggested that if the duty of candour complements the public bodies’ complaints process, it could reduce reliance on that process and provide ‘outcomes that people might otherwise have sought from making a complaint’.

Measuring candour

3.9 Throughout this project an obstacle to fully understanding the effects of regulatory interventions on candour is that it is difficult to measure candour quantitatively. Many stakeholders and regulators observed that difficulty in measurement stems from the qualitative nature of candour, one stakeholder suggested that the duty of candour is ‘mainly a qualitative attribute’.

3.10 It was also noted by one regulator that ‘care needs to be taken with using fitness to practise as a measure, as effective candour by practitioners might actually reduce the likelihood of patients raising concerns’. Another stakeholder highlighted that regulators are in a better position to measure the absence of candour through fitness to practise allegations than the practice of candour. A few stakeholders observed that measurement of compliance to the duty of candour can be useful but does not ensure that candour is meaningful. One stakeholder organisation noted: ‘The problem is, however, that the focus is on ‘compliance’ rather than professionalism. There is a wish now to ‘count’ what happens rather than supporting professionals with dealing with difficult situations.’ One professional organisation pointed out that the duty of candour has ‘less to do with a culture of compliance and more to do with a culture of responsibility’. The potential negative aspects of counting candour were also observed by another organisation that was concerned that the creation of a system to measure compliance could create ‘perverse incentives and undesirable outcomes’.

3.11 Some stakeholders suggested that it was possible to measure candour. This could be aided by greater consistency about how the issue is approached across the health and care sector. If a system of measurement were to be instituted, stakeholders suggest the following as sources of data for measurement (this is not an exhaustive list):

- Feedback from patients and families on candid behaviour of professionals
- Fitness to practise (FTP) data from professional regulators

• Healthcare providers
• Peer review
• Annual staff survey
• System regulators
• Complaints bodies.
4. Factors that encourage and discourage candour

4.1 In this chapter we will outline the main factors that discourage and encourage candour in professionals. Many of the factors we discuss below we identified previously in our advice to the Secretary of State in 2013. Although it is a limited sample, it is striking that the word ‘fear’ was mentioned when discussing barriers to being candid by 37 of the 60 organisations/individuals that responded to the questionnaire and call for information. This could be fear of litigation, fear of the regulator striking a professional off their register, or fear of public and media perceptions and the ensuing impact on a professional’s livelihood.

4.2 This chapter is not a comprehensive list of all the factors encouraging and discouraging candour. For the factors which discourage candour we have sometimes picked out ideas suggested by questionnaire responses to remedy the issue and examples of how organisations are attempting to change that discouraging factor. We go into more detail in the next chapter over how regulators have worked to overcome those barriers.

Workplace

4.3 There was a widespread view amongst questionnaire respondents that organisations which had a blame culture, or a culture of defensiveness, were not environments in which the professional duty of candour could thrive. A few identified this as the key factor for influencing candour.

4.4 One complaints organisation commented that if an organisation’s culture is defensive then staff can be fearful about making admissions as they may be ‘criticised or judged by colleagues and employers’. The organisation also noted that it had seen letters where Boards had downplayed the significance of comments professionals had made to patients suggesting that the comments were inaccurate or needed to be seen in context. The organisation noted that ‘this approach is not likely to encourage the professionals involved to continue to be open with patients’.

4.5 A professional body similarly noted that professionals may fear being ‘isolated from colleagues’ if they were candid. Professionals may find their careers affected as a result of being candid, as one education organisation put it, there is a fear that ‘if you make a fuss you won’t end up working in that team’. The same organisation also pointed out that there could be a detrimental impact on a professional’s career if they raised a concern that may ‘annoy’ senior colleagues and similarly for trainee progression due to any investigations that may result from raising concerns. Another organisation observed that trainees do not ‘always feel empowered to apologise individually due to their perception of their status’ within their teams.

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17 Candour, disclosure and openness Learning from academic research to support advice to the Secretary of State, Professional Standards Authority, 2013.
4.6 However, healthcare provider organisations can also encourage candour in professionals. A stakeholder noted that a culture of candour can exist in organisations where there is good leadership which understands its staff. This means staff can be supported in moving towards an open culture. Similarly, some discussion group participants felt that candour could be encouraged by positive relationships between different types of regulated professionals who worked together, as well as regulated and unregulated staff.

4.7 A professional’s level of autonomy, suggested one organisation, could influence how confident they feel about being candid with patients. The organisation observed that ‘autonomous clinician’ roles such as general practitioners ‘felt more at ease’ than other professionals when being candid due to their ‘greater sense of accountability’.

4.8 We also saw in questionnaire responses that professionals may lack belief in candour having any meaningful or constructive outcomes in order to prevent a recurrence.

The importance of timeliness

4.9 A professional’s workload and the associated stresses of a heavy workload can mean professionals are limited in the time they have to spend with patients when a problem has occurred. A number of organisations and discussion group participants noted the negative effects of workforce shortages on workloads and candour by extension. One professional body noted that professionals delivering care outside of normal working hours, sometimes under ‘intolerable pressure and workload’ can be compromised in their ability to adequately deliver high quality care, of which candour is a component.

4.10 One stakeholder noted that the authenticity of an apology can be affected by the time between an incident and a claim. A professional’s recollection of the events that happened can be limited due to the time that has passed, the stakeholder suggested. In patients’ minds, this lack of recollection can call into question the authenticity of an apology. One means to reduce the chance of this occurring is good record-keeping. Additionally, a firm of solicitors highlighted that when things go wrong patients often feel ‘out of the loop’ and with little support from a hospital or Trust whilst it conducts an investigation, which can often be ‘lengthy’.

4.11 It was noted in discussion groups that a professional’s mistake might not come to light immediately. In some circumstances a professional might only realise they have made a mistake at a later date, or even when they are contacted by their regulator. It was suggested that one impact of the passage of time was that it could be harder for a professional to acknowledge that they had not done their best on a particular day.

4.12 Discussion group participants also discussed how windows of opportunity for candour could be created, or indeed lost, in the regulatory process. This has more relation to candour of professionals to regulators than to patients but is an interesting observation nonetheless. The group facilitator, Annie Sorbie, later termed this a ‘regulatory space’ for candour. An example of lost regulatory space is if a robust local investigation of a professional’s conduct had not taken place prior to referral to the regulator. Regulatory space for candour might be created
where a regulator’s legislative framework has the flexibility to allow and encourage a candid two-way exchange of information at an early stage before formal aspects of the process are invoked. Communication with professionals is seen as key in order to encourage engagement with the fitness to practise process and there needs to be support structures and resources available to address training needs resulting from candour failings. This may be of particular interest to regulators in relation to consensual disposal18 or continuing fitness to practise as potential tools to create a ‘regulatory space’.

Education and training

4.13 A number of questionnaire respondents and discussion group participants considered education and training to be key to encouraging candour. Education and training bodies can help trainees understand issues of candour and the implications of being (and not being) candid.

4.14 The cornerstone of candour is the communication between a professional and a patient. It was noted by a few stakeholders that education and training bodies can show trainees how to have candid conversations with patients when things have gone wrong. It was observed by organisations that some professionals lacked communication skills to apologise effectively and that others lacked confidence to communicate candidly with patients. A professional body highlighted the importance of training in communication skills in order to support professionals in having open and difficult conversations with patients. It also noted that training would help dispel fears of the legal implications of apologising. The body considered that it would be useful for both professional and system regulators to deliver training in those communication skills. The body referred to the ‘useful’ practical workshops of the General Medical Council (GMC) on its guidance as a model for this type of training. We also note from other literature and the discussion groups that communication needs to be tailored to patients. They are not one homogenous bloc and will want information communicated in different ways depending on their preference.19

4.15 It was noted by one education organisation that interprofessional education helps to prepare professionals to deliver the professional duty of candour in a multidisciplinary context. It noted that regulators have an important role to play in promoting and enforcing the delivery of interprofessional education in professional courses.

4.16 There are limits though to how much education and training can influence professionals to be candid when they get into the workplace. One education stakeholder, referring to Miller’s Pyramid (see below), informed us that it had ‘little doubt’ that medical trainees know (‘knows’ and ‘knows how’) their duty to be candid and can demonstrate competence to adhere to it (‘shows’). However, the

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18 Consensual disposal is a process used by some of the regulators in cases where there is agreement on the facts of the case and proposed sanctions, and where there may be no public interest or need for a hearing.

19 Sir David Dalton and Professor Norman Williams (2014). Building a culture of candour, Royal College of Surgeons, p10.
organisation considered that when trying to comply in practice with that duty ('does'), medical trainees were subject to other pressures such as blame culture.

Figure 2: Miller’s Pyramid, a way of ranking clinical competence both in educational settings and in the workplace

Fear of the regulator and litigation

4.17 The twin prospect of regulatory and criminal or civil prosecution proceedings may discourage professionals from being candid. Some stakeholders considered that professionals may worry that regulators may not be fair to professionals who have been candid and that the regulator may be perceived to be punitive or looking to apportion blame.

4.18 The case of Dr Hadiza Bawa-Garba was frequently mentioned in questionnaire responses; a third of the questionnaire responses drew attention to the case. Stakeholders pointed to the Bawa-Garba case as an example of an individual being held responsible by a regulator for organisation-wide problems and that admission of errors may result in criminal proceedings. A number of stakeholders and discussion group participants commented that this case negatively impacted trainees and set back work to promote professionals’ reflections on errors. High profile cases, and the negative media which go with them, was also cited as a barrier to candour for professionals.

4.19 Professionals’ fear of civil or criminal prosecution was often discussed in questionnaires. Many mentioned that there is fear amongst professionals that apologising to a patient would lead to negligence claims. There have been attempts to dispel the continuing perception that an apology is an admission of liability, for example NHS Resolution’s Saying Sorry leaflet and the General Dental Council’s (GDC) guidance on candour. One educational body suggested

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20 Bawa-Garba is a doctor convicted of gross negligent manslaughter. She was suspended by the Medical Practitioners Tribunal Service. The GMC appealed the decision to suspend, which resulted in Bawa-Garba being struck off after the GMC. The GMC’s decision was successfully appealed by Bawa-Garba. More information can be found in this article: Bawa-Garba: timeline of a case that has rocked medicine, Pulse, 2018

21 NHS Resolution (2017). Saying Sorry

22 General Dental Council. Being open and honest with patients when something goes wrong.
that regulators have a role in ‘destigmatisation of those that disclose failings’. A defence body told us that it made sure that its members were aware that ‘problems are more likely to arise if there is a lack of candour, and less likely if there is openness and honesty with patients’.

4.20 Behaving candidly can be a means to reducing the chance of litigation. For example, the University of Michigan Health System has pioneered a malpractice scheme based on early disclosure of errors to the patient, and found that both the litigation costs and the number of claims decreased as a result.23 A law firm suggested that compliance with the duty of candour ‘would help to resolve those claims which do have merit at a much earlier stage and without the need for prolonged litigation and inflated legal costs’. However, one representative organisation expressed concern about law firms that specialised in ‘no-win no-fee’ approaches lengthening cases against professionals who have tried to do the right thing.

4.21 Recent legislation to decriminalise dispensing errors (Pharmacy (Preparation and Dispensing Errors – Registered Pharmacies) Order 2018)24 was heralded in a few questionnaire responses as a step towards encouraging candour in pharmacy professionals. One organisation noted that prior to the Pharmacy Order, pharmacists were ‘reluctant’ to report errors as a dispensing error could be treated as a criminal offence even if there was no ‘malicious intent’. It further noted that the removal of the threat of legal prosecution could lead to ‘stronger and more positive attitudes to candour’ by pharmacists. However, this change in legislation only applied to community pharmacists. It did not apply to pharmacists working in non-community settings such as hospitals.25

Professional regulators

4.22 Many respondents to the questionnaires observed that regulators have a role in encouraging candour, describing the role as ‘significant’, ‘vital’ and ‘important’ among other phrases. However, some respondents did not think regulators were well-suited or even had a role to encourage candour. One professional body noted that a regulator should have a minimal direct role informing registrants of the existence of guidance on candour and how it interprets it. It should have no other direct role, emphasising the role of professionals and support organisations. It further noted that it is a ‘harrowing enough experience to find out something had gone wrong and discuss this with a patient, there does not need to be an additional regulatory layer to that process in all situations’.

4.23 In all questionnaires, we asked: ‘What role do professional regulators have in encouraging candour among their registrants?’ The main expectations of what the regulators should be doing are:

- Set standards for professionals to uphold

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23 Professional Standards Authority (2013). Candour, disclosure and openness Learning from academic research to support advice to the Secretary of State pp9-10.
24 Pharmacy (Preparation and Dispensing Errors – Registered Pharmacies) Order, 2018
25 A government consultation on extending decriminalisation to other pharmacy professionals closed in September 2018. It is important to note that questionnaire responses were received in late May of 2018.
• Ensuring professionals are aware of the duty of candour
• Creating an environment in which professionals can be honest
• Providing clear guidance to professionals, which can be aided by examples
• Ensure training providers are making sure trainees are aware of their duty to be candid
• Work with other healthcare organisations to ensure professionals are being supported to be candid
• Encourage candour through revalidation
• Taking action when a professional has not been candid
• Be part of a no blame culture and be clear on how they will act if a professional is candid.26

4.24 These expectations show that professional regulators might have a diverse role in encouraging candour. A recurring theme in questionnaires and discussion groups is that there are limitations to how much regulation can influence the candour of professionals. Regulators are just one part of the healthcare system and they need to forge strategic relationships with other parts of the system such as employers and professional bodies to support a culture of candour.

4.25 On fitness to practise, it was noted by an educational organisation that there is a ‘perception that the focus is solely on the individual’s behaviour and not necessarily taking into account systems issues/failures taking into account the published work on failures in systems’. It went on to suggest that ‘in general any untoward incident is because of 80 per cent latent failures built into the system and 20 per cent active failures, action/omission by individuals’. Discussion group participants noted that regulators needed to strike the right balance when dealing with candour in fitness to practise cases. For example, if a professional has been candid about their mistakes, and this is treated as a mitigating factor, then this might encourage candour in other professionals. However, the weight attached to such mitigation will depend on the underlying facts of each case.

4.26 A prominent theme of stakeholder responses was that regulators should be fair and not punitive. Many respondents and discussion group participants considered the regulatory sector and the wider health and care sector to be moving away from the ‘blame culture’. Many pointed out though that the move away from blame culture had been hampered somewhat by the Bawa-Garba case. Some discussion participants had concerns that an overly adversarial and punitive approach in regulatory proceedings could have the perverse effect of discouraging professionals from being open about their mistakes. Overall, there was widespread support for positive steps to encourage candour, for example through education, and promoting ‘positive’ candour at a local level. On the other hand, some participants also discussed the role of fitness to practise proceedings in

26 One stakeholder noted that regulators, as well as their registrants, should be candid. This was also a topic of discussion in one of the discussion groups, where participants felt it was important for regulators to be candid about their own failings.
sending out a clear message to professionals and the public about the importance of being candid. Together this highlighted the balance that would need to be struck in regulatory proceedings.

4.27 One educational organisation responded to the questionnaire suggesting that regulators should be ‘transparent, supportive and consistent in their approach to dealing with trainees and registrants who have acted candidly’. That organisation further noted that actions taken against registrants must be proportionate to the circumstances.

4.28 A few organisations noted there had been a positive move forwards in candour of professionals but ascribed the success of that progress mainly to non-regulatory interventions. For example, the Scottish Patient Safety Programme and ‘Patient Stories’ were praised by some stakeholders for their influence on professionals. The former helped highlight the importance of learning, whilst the latter have been described as a ‘powerful engagement tool’ and have helped contextualise for professionals the positive effects of candour on patient safety. One questionnaire respondent noted that health and care staff feel more empowered to be open and honest but attributed this mainly to the statutory duty of candour.

4.29 Finally, regulation may not affect the candour of many professionals as they may be candid anyway or seek advice on candour from other organisations. Many respondents cited non-regulatory sources of advice for professionals on candour. One stakeholder noted that even before the regulators had guidance on candour it had been the organisation’s practice, for over 50 years, to advise professionals who seek its assistance when something has gone wrong to tell patients and to apologise. Professionals who seek its assistance follow this advice, principally because it is the right thing to do and have done so long before it featured specifically in regulators’ guidance. Another respondent told us some of its members questioned whether the 2014 changes have had any discernible and practical impact to date, it gave one example below:

‘We have systems in place for this, but I am not sure DoC [duty of candour] changed much for those providers who were already encouraging an open and transparent culture of reporting and investigation of incidents. So we are very positive and supportive about the DoC principle, but felt that we were taking that approach already so it hasn’t significantly changed how we work.’

Are there limitations to candour?

4.30 One stakeholder organisation responded to the questionnaire suggesting that there are ‘limitations’ to candour and that healthcare providers need to ‘respect what patients may not want to know’. The organisation suggested that ‘codes of practices for promoting candour need to be aware of the boundaries’.

4.31 One individual respondent to the call for information suggested that currently there are ‘overreactions’ and discussed the need for proportion when being candid through their example scenario:

‘my colleague was involved in an infusion mistake of electrolytes, the patient was managed appropriately and discharged but because some of the
mistakes didn’t come to light until after discharge, some are proposing a meeting with the patient. I think in this case, a simple phone call constructed well, handled professionally is sufficient unless the patient wishes further information.”

4.32 Some of the factors discussed in this section were also explored in one of the discussion groups. Some participants commented that there may need to be ‘subtlety in explanations of risk’ and that there were ‘shades of grey’. It was suggested that because discussions around candour could be rather ‘nebulous’ case studies might be helpful to guide professionals when faced with a dilemma of candour.

4.33 On the issue of withholding information from patients when something has gone wrong, the GMC and the Nursing and Midwifery Council’s (NMC) joint guidance on candour notes that patients will normally want to know more about when something has gone wrong but a professional should give them the option not to be given every detail. If a patient does not want more information a professional should explore their reasons for their decision and explain the consequences for the patient. A professional should then respect the patient’s wishes, recording this and making it clear to the patient that they can change their mind.27 The GDC’s guidance for its registrants makes similar remarks.28

4.34 It is worth noting the Dalton/Williams Review of candour on this issue. The review authors suggest that any decision to depart from normal expectations of disclosure ‘needs to be considered thoroughly and based on clear evidence’. It goes further to caution that professionals and organisations should be ‘sceptical’ of paternalistic arguments and that such arguments should be ‘used sparingly rather than becoming a default attitude’.29

**Indemnity and defence bodies**

4.35 Questionnaire responses mentioned that professionals may be fearful about how candour can affect their insurance indemnity arrangements, for example by increasing premiums or even nullifying insurance. The General Osteopathic Council (GOsC) noted that some respondents to its consultation on revised Osteopathic Practice Standards in 2017 thought that a proposed standard on duty of candour was not clear and wanted more guidance about the relationship between candour and insurance.30 Participants in our discussion groups noted that there was concern amongst professionals that if they apologised they might ‘lose’ their insurance cover, it was acknowledged that although this was not true the ‘myth’ persisted. A defence organisation told us that indemnity arrangements ‘should not and do not’ have an effect on the ability of professionals in its remit to be honest to patients, and that it made clear to its members nothing should prevent them from telling patients when things go wrong or apologising. The defence body further noted that defence bodies have an important role in

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28 GDC (2016). *Being open and honest with patients when something goes wrong*.
30 It was a small proportion of respondents that did not consider the guidance was clear: 9 out of 122.
encouraging candour as they are often the first place a professional may seek advice.

4.36 This relationship – between candour and professionals receiving representation and advice (from defence organisations or lawyer) during fitness to practise proceedings – was also considered by some participants in the discussion groups. An observation was made that some professions – particularly those that were lower paid – were less likely to have representation before and at hearings. As a result, they may not have the benefit of the type of advice encouraging candour at an early stage, as outlined above. Fitness to practise proceedings can provide an opportunity for professionals to learn from their experiences and improve their conduct going forward. However, there was a suggestion by some participants that where professionals were not well supported during hearings, or indeed did not engage with fitness to practise proceedings at all, they may find it hard to explain the context of their failings and/or to express how they had taken steps to remediate these mistakes.

4.37 Conversely, it was also noted in one discussion group that represented professionals may be ‘cajoled’ into taking courses, and to show insight and remediation. However, it was suggested that some professions, for example outside of medicine, do not have the support structure and resources for re-education.

Professionals’ expectations of making an error

4.38 For a professional, coming to terms with the fact that they are likely to make a mistake in their career could encourage them to be candid when something has gone wrong. It was suggested by one regulator that as healthcare professionals tend to be ‘high-achievers’ they may be inadequately prepared to deal with error or failure. In healthcare, there is always a possibility that an intervention can go wrong or even high achievers may make mistakes.

4.39 Another report on candour observed: ‘clinical care is inherently risky, and while organisations and individuals must do all they can to minimise risks, it will never be possible to eliminate them fully. Candour will therefore always be necessary…’.31 Discussion group participants and a few questionnaire respondents also noted that it is not realistic to expect humans to never make errors, with one participant noting that ‘no professional will be error-free their entire career’. Therefore, enabling professionals and trainees to understand there is a chance they will make errors in their careers might encourage candour.

5. How have regulators embedded candour?

5.1 In this section we explore how regulators have attempted to embed candour. Some respondents commented that there were nuances and differences between regulators in approaches, one stakeholder commented on the variation between regulators in approaches to fitness to practise. Another stakeholder observed that there is a ‘perceived inequity’ in the way different professions are treated by regulators when there is a clinical error and a belief that doctors ‘escape blame and punishment’ compared to other colleagues. However, one organisation responding to the questionnaire did welcome the ‘cross-regulator’ approach to candour, noting that there is ‘strength in consistency of language and approach’.

Standards, codes and accompanying guidance

5.2 A key means for a regulator to show that candour is expected of a registrant is by having it as a standard of practice. All the regulators have standards relating to candour. The main standards of each regulator relating to candour can be found in Appendix A of this paper.

5.3 Beyond the main standards, there are also other standards in a regulator’s code or standards which reinforce candour. For example, the General Chiropractic Council (GCC) has the main standard of:

| B7: Fulfil the duty of candour by being open and honest with every patient. You must inform the patient if something goes wrong with their care which causes, or has the potential to cause, harm or distress. You must offer an apology, suitable remedy or support along with an explanation as to what has happened. |

Figure 2: GCC standard of duty of candour

5.4 The GCC also has the following standards elsewhere in its code, which reinforce the need for registrants to be candid:

| B: Act with honesty and integrity and maintain the highest standards of professional and personal conduct. |
| F1: Explore care options, likely outcomes, risks and benefits with patients, encouraging them to ask questions. You must answer fully and honestly, bearing in mind patients are unlikely to possess clinical knowledge. |
| A3: Take appropriate action if you have concerns about the safety of a patient. |

Figure 3: Various GCC standards relating to candour

5.5 In addition to the standards and codes for professionals, two regulators have standards for businesses. The General Optical Council (GOC) recently consulted on new draft standards for businesses which included explicit references to candour in its standard for business practices to be open and transparent. The General Pharmaceutical Council (GPhC), which regulates premises, has a

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32 General Chiropractic Council (2016). Guidance on candour
33 General Optical Council (2018). Standards for Optical Businesses
standard of ‘There is a culture of openness, honesty and learning’ as well as other standards around raising concerns, learning from mistakes and staff empowerment to provide feedback and raise concerns.34

5.6 A few stakeholders have noted that the regulators have had some success in highlighting to a wide audience of professionals and other stakeholders the worthiness of apologising and actions to avoid the reoccurrence of something going wrong. There were positive comments also for how regulators communicated what candour means in practice for professionals.

5.7 One stakeholder noted that the regulators’ updating of standards, guidance and codes raised the profile of candour, and that there was a focus on registrants using standards and codes to support practice, rather than being used by employers as a ‘stick’. They commented that this helps promote good practice.

5.8 The GOC found that 86 per cent of registrants it surveyed were confident in their ability to meet the revised standards of 2016 (when candour related standards were added) and only 2 per cent were not aware of the revision of standards. When looking at how registrants’ practice has changed since the new standards were introduced, 16 per cent said they focus more on candour and communication with patients. However, when discussion group and interview participants in the same project were asked if there were any standards that were unclear or unhelpful, they cited the duty of candour standard ‘saying that it was confusing that if a mistake is made there should be an apology to the patient but no admission of liability’.35

5.9 The NMC noted that the introduction of an explicit candour standard to its Code has ‘ensured that there is a growing awareness of the need for candour as a core element of professional practice’. However, one organisation suggested that the NMC Code and joint guidance with the GMC lack clarity and specificity, which then make it harder for professionals to know when they need to comply, and therefore less able to do so and can even set up a tension between the managers and clinicians. It made reference to an example of one of its members:

‘In my own organisation, duty of candour is enforced and managers are questioned if it is not acted upon when a patient safety issue occurs. This can be difficult for clinicians in end of life cases where care has not been as good as it should have been but has not caused or accelerated the patient’s death, but being honest with family can cause further distress. There is certainly a challenge in managing these few cases.’

5.10 The organisation pointed towards the organisational duty of candour as being better than the professional duty because it ‘sets out how serious the harm has to be before the duty of candour process must be initiated.’ The organisation also went on to say: ‘In the joint guidance there is even a discussion about whether near-misses should be reported to patients and families, without much of a steer about when this should take place. However, there is at least a recognition in that section that reporting that things have gone wrong can be distressing for patients and their families and allows the health professionals to take this into account’. We

34 General Pharmaceutical Council (2018). Standards for registered pharmacies
are conscious from other feedback we received that being overly prescriptive in guidance and codes can negative consequences. Case studies may have a role to play in helping professionals better understand how guidance and codes can be applied.

5.11 The GCC noted that it has ensured that its registrants are ‘fully aware’ of their duty of candour through publishing and promotion of guidance and drawing attention to the joint statement of candour by regulators. It also noted that in 2015 and 2016, it administered surveys to education providers and chiropractic students on attitudes to professionalism, although the number of individuals who responded was low, the surveys showed that the undergraduate students who completed the survey were aware of the requirements of the duty of candour even though the word ‘candour’ was not used. Survey participants were given a list of hypothetical scenarios that displayed a lack of professionalism and were asked to indicate whether they believed the situation to be ‘wrong.’ The total number of individuals who completed the survey in both years was very low, however, all student participants agreed that the hypothetical situation that fell under the duty of candour (‘A fellow student asks you to cover up a mistake in the clinical care of the patient’) was wrong with 89 per cent indicating that they believed it was ‘seriously wrong.’

5.12 The Health and Care Professions Council (HCPC) observed that it has seen a ‘positive shift’ in registrants’ attitudes to candour since its standards were changed. Feedback indicates that its registrants are aware of their obligations in this area and feel supported by the HCPC when raising concerns. The HCPC also regularly receives requests for written confirmation of its expectations from registrants to support them in this regard. It also noted that it continues to highlight the requirements to be candid in its stakeholder meetings and has received positive feedback.

5.13 Five regulators (GCC, GDC, GMC, GOC and NMC) have produced candour specific guidance documents for registrants to supplement standards and codes. The GDC noted that guidance not only sets out requirements but can promote an idea to professionals. When publishing its guidance on candour the GOC considered that guidance can assist registrants in applying a regulatory standard and extra confidence in applying the standard.36 The GPhC has guidance – In practice: Guidance on raising concerns – around applying its standard relating to candour and raising concerns. The guidance states that the duty of candour is at the ‘heart’ of the standard.37

5.14 The GMC and NMC developed joint guidance on candour for doctors, midwives and nurses.38 The guidance sets out the standards expected of the three professions. The guidance has received national coverage, including in the traditional media, press statements and tweets from the Health Secretary, King’s Fund and others. In addition, the NMC produced a number of case studies to help its registrants with the duty of candour, what it means for their practice and how to

36 General Optical Council (2017). GOC publishes guidance on professional duty of candour.
37 General Pharmaceutical Council (2017). In practice: Guidance on raising concerns
38 General Medical Council and Nursing and Midwifery Council (2015). Openness and honesty when things go wrong: the professional duty of candour
meet it in a range of scenarios. These case studies were developed with the help of practising midwives and nurses.  

5.15 The GOsC’s recent consultation on Osteopathic Practice Standards found that a large percentage of respondents felt the candour guidance was clear and easy to use. They were asked the following question: ‘10. Is the updated standard D3\(^\text{40}\) and its guidance in relation to the duty of candour sufficiently clear and easy to use?’ The GOsC received 122 responses to this question of which 113 considered the guidance was clear and accessible and nine did not. Those that said ‘no’ wanted more guidance about the relationship between an apology and their professional indemnity insurance.  

**Education and training (prior to full registration with a regulator)**

5.16 As mentioned in the last section, education and training is a key way to encourage candour among health and care professionals. All the regulators have made steps to embed candour in education and training. Four of the regulators (GCC, GDC, GMC and NMC) explicitly mention candour in their standards for organisations providing education and training to trainees. These can be found in Appendix B of this paper. The NMC found that there was strong support from stakeholders to embedding the professional duty of candour in its new Education Standards.

5.17 The HCPC revised its standards for conduct, performance and ethics in 2016, this included a provision for the duty of candour. The HCPC has required education providers to confirm, via annual monitoring,\(^\text{41}\) that they have embedded the revised professional standards relating to candour. Additionally, the HCPC has revised its standards for education providers to explicitly require education providers to evidence how their learning outcomes ensure learners understand the implications of the conduct, performance and ethics standards like the requirement to be candid.

5.18 The GPhC and the Pharmaceutical Society of Northern Ireland (PSNI) noted that in their capacity to quality assure\(^\text{42}\) the education and training of MPharm pharmacists, they require universities providing the training to teach the standards of candour expected of pharmacy professionals. The GPhC also noted that pharmacy technician providers going through the accreditation and recognition process must provide evidence of how candour is embedded in their training.

5.19 The GMC refers to the duty of candour in its Generic Professional Capabilities Framework under requirements for professional values and behaviours. The Framework seeks to embed common generic outcomes and content across all postgraduate medical curricula, which will need to be embedded in every postgraduate curriculum by 2020.\(^\text{43}\) An educational organisation noted that this is a ‘very positive step as it gives a level of clarity for trainees and trainers’.

\(\text{39}\) Nursing and Midwifery Council (2015). The professional duty of candour: Nursing case studies  
\(\text{40}\) Standard D3 states: ‘You must be open and honest with patients, fulfilling your duty of candour.’  
\(\text{41}\) Annual monitoring is a process where the HCPC considers whether a programme continues to meet education standards and that individuals who successfully complete the programme are able to meet the relevant proficiency standards.  
\(\text{42}\) The PSNI quality assures MPharm students through a memorandum of understanding with the GPhC.  
\(\text{43}\) General Medical Council (2017). Generic professional capabilities framework
5.20 The GOC stated that as part of its ongoing Education Strategic Review it is embedding more professionalism and professional skills training into undergraduate education, meaning its registrants have a good knowledge of the duty of candour early in their careers.

5.21 Other regulators told us about how they raised awareness of issues of candour with students and trainees. The HCPC has updated its guidance to students on conduct and ethics to reflect the duty of candour. The PSNI meets with MPharm students every year to discuss its code, and the importance of the duty of candour is discussed. The PSNI also told us that pre-registration trainees are required to attend an induction day at the beginning of each registration year, in which emphasis is placed on principles (such as the duty of candour) of the PSNI Code and the obligations of professionals and trainees to comply. Pre-registration tutors assess the performance of trainees against the principles of the Code quarterly.

5.22 Additionally, a stakeholder informed us that the GMC delivers compulsory professionalism sessions in Northern Ireland to foundation year two trainees, GP trainees and new appointments to specialty training in Northern Ireland. The sessions are evaluated to measure the trainee perception and understanding of professionalism. The importance of being open and honest and the duty to report concerns is emphasised.

5.23 The GMC’s compulsory professionalism sessions in Northern Ireland were commended by an organisation. It further noted that trainees ‘on the whole are very open and honest and readily give feedback’ and that education and training bodies have been successful in encouraging those in training to be candid through e-portfolios where trainees reflect on mistakes and discuss how to communicate this to patients.

5.24 In the context of education, a discussion group participant suggested that students’ soft skills, such as candour, may be seen by universities as less of a priority for students than their technical skills. They suggested this could send out a message to students about what was ‘important’. They further noted that in order to embed candour this needed to be done at an early stage – and not just at the point that a professional was dealing with a mistake.

Continuing fitness to practise

5.25 The NMC noted that revalidation has a role in raising awareness of candour to registrants and enabling them to reflect on the role of candour in their practice. The GOC requires optometrists, dispensing opticians, contact lens opticians and therapeutic prescribers to fulfil an element of competence in candour for continuing education and training (CET). The duty of candour is highlighted in the GMC’s updated revalidation guidance in the context of doctors participating in significant event reviews. Additionally, the duty of candour is referred to in the GMC’s information-sharing principles for revalidation. One professional body stakeholder cautioned that although it is possible for the duty of candour to be included in the appraisal process of a professional and given ‘a weight’ in the

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44 General Optical Council (2015). *What are the CET requirements?*
45 General Medical Council (2018). *Guidance on supporting information for appraisal and revalidation*
46 General Medical Council. *Information sharing principles*
revalidation process of medical professionals, it ‘needs to be done in a way that does not discriminate against those practising in higher risk environment’.

**Fitness to practise**

5.26 A number of regulators feature candour in their fitness to practise documents. The GDC, GOC and GPhC\(^{47}\) have sections explicitly discussing candour and focusing on it in their respective fitness to practise indicative sanctions guidance (ISG). The NMC’s online fitness to practise library has a section about candour.\(^{48}\) Sanctions guidance for the Medical Practitioners Tribunal Service (MPTS) and GMC refers to the GMC and NMC’s joint guidance and has a section on expressions of regret and apologies.\(^{49}\) The HCPC’s indicative sanctions guidance mentions that ‘Panels should regard registrants’ candid explanations, expressions of empathy and apologies as positive steps’.\(^{50}\) The HCPC and PSNI both consulted recently on revising their indicative sanctions guidance, both included sections focusing on issues relating to professionals’ duty of candour.\(^{51, 52}\) The GOsC also consulted on doing the same in 2017.\(^{53}\)

5.27 These documents show that, broadly speaking, there can be positive and negative circumstances in which candour can manifest in fitness to practise. For example, this is exhibited in the GPhC’s guidance which guides the committees to view registrants’ apologies and candour as ‘positive steps’ whilst committees are warned to take seriously (and consider sanctions at the upper end of the scale) for the deliberate avoidance of candour.\(^{54}\)

5.28 The NMC noted that it introduced an allegations coding framework in 2017 which specifically includes codes related to candour. These specific allegations can be found in the annex of the Authority’s report on categorisation, which lists the allegation frameworks of all the regulators.\(^{55}\) We noted in the main report of the categorisation project that two regulators had allegations that used the word ‘candour’ (GOsC and NMC). We noted though that it is possible for regulators to record fitness to practise issues of candour, without specifically mentioning ‘candour’, through other categories they may be using. For example, the GMC’s ‘Show respect for patients’ category (displayed on the next page) covers issues which could be related to candour.\(^{56}\)

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\(^{47}\) In addition to the GPhC’s [Fitness to practise hearings and sanctions guidance](https://www.gphc.org.uk/fit-to-practise/guidance), the GPhC’s [Investigations and threshold criteria guidance](https://www.gphc.org.uk) also reiterates the importance of ‘acting with openness and honesty’.

\(^{48}\) Nursing and Midwifery Council. [Has the concern been remedied?](https://www.nmc.org.uk/)

\(^{49}\) Medical Practitioners Tribunal Service. [Sanctions guidance for members of medical practitioners tribunals and for the General Medical Council’s decision makers](https://www.gmc-uk.org/Sanctions/)

\(^{50}\) Health and Care Professions Council. [Indicative Sanctions Policy](https://www.hcpc-uk.org)

\(^{51}\) Health and Care Professions Council. [Consultation on the revised Indicative Sanctions Policy](https://www.hcpc-uk.org)


\(^{54}\) General Pharmaceutical Council (2017). [Good decision making: Fitness to practise hearings and sanctions guidance](https://www.gmc-uk.org/)

\(^{55}\) Professional Standards Authority (2017). [Categorisation of fitness to practise data annexe](https://www.professionalstandardsauthority.org.uk)

\(^{56}\) Professional Standards Authority (2017). [Categorisation of fitness to practise data](https://www.professionalstandardsauthority.org.uk)
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Figure 4: GMC sub-categories of ‘Show respect for patients’

5.29 Many discussion group participants noted that lack of candour was an issue that frequently arose in fitness to practise cases. However, it was widely acknowledged by participants that such cases were closely interlinked with dishonesty and thus expressed as that, instead of ‘candour’. Lack of candour was also associated with poor communication and working relationships.

5.30 There were concerns in the discussion groups about how fitness to practise committee members would distinguish between candour and dishonesty in allegations, and whether this could be perceived as introducing ‘different grades of dishonesty’. It was noted by some that there was already some confusion in this area as between the varying terminology in charges such as ‘dishonest’ and ‘misleading’.

5.31 A second challenge of prosecuting candour cases discussed in the groups related to the evidence gathering process. For example, candour cases might relate to what a professional thought or knew at a particular time (in other words, their state of mind), or exactly what they did (or did not) say to a patient on a particular day. This could make some cases of this type difficult to prove. It was suggested that candour cases could relate to circumstances where it is difficult to separate an individual’s lack of candour from broader systemic issues. As noted above, it was also observed that sometimes a lack of candour might not emerge until well after the primary failing occurred.

5.32 One organisation noted in its questionnaire response that it did not support regulators becoming ‘habitually involved in enforcing the process side of candour’. It suggested that regulators should be focused on dishonesty and lack of competence because there is a risk that if candour charges are added to clinical error charges, the response to a mistake will ‘look disproportinate and punitive upon one individual and make practitioners even less likely to want to admit to mistakes’.

5.33 The GOC and PSNI both noted in their questionnaire responses that they have provided training on the duty of candour. The GOC did this with its case examiners and its fitness to practise committee members, whilst the PSNI told us that it recently held fitness to practise training for its Scrutiny and Statutory Committee members, in which it addressed the duty of candour and the role that Committees can play in ensuring the right allegations are brought before them based on the evidence presented. Some discussion group participants said there had been training which addressed candour for those involved in fitness to practise.

5.34 Although focusing on candour of professionals to regulators rather than patients, one stakeholder commented that fitness to practise processes are increasingly
encouraging registrants to be candid to regulators: the HCPC and the NMC have worked a great deal around early engagement with registrants referred in the fitness to practise process. The organisation considered that overall there had been a move by regulators, although with some inconsistency, from an adversarial approach to encouraging registrants to be open and honest.

5.35 The NMC observed that if success of encouraging candour is measured in terms of lowering the volume of fitness to practise cases involving lack of candour, it is too early to tell as it only recently started recording this level of detail and is not in a position to comment on any trends at this juncture. On the other hand, if success is measured as an increase in the number of registrants being candid to patients, this would pose an issue of how to measure since registrants are who are candid are less likely to be referred to the fitness to practice process. Therefore, there is little fitness to practise data on professionals who have been candid. This means that although the amount of lack of candour can be measured, there may be potential issues with how to weight this against the prospect that professionals are being candid.

5.36 One stakeholder suggested that there had been a weakening in medical professionals’ trust of the GMC due to the Bawa-Garba case. This meant that professionals had concerns over ‘why and how they should be candid’. It was noted that it would take several years for the GMC to regain lost trust, despite the fact that the concerns arose around the possible misuse of reflective notes rather than the duty of candour. A number of other stakeholders made clear that professionals’ concerns over misuse of reflective notes could hinder their compliance with the duty of candour. Relatedly, there was concern that regulators can often be seen as on the ‘patient's side’ and act punitively towards registrants.

5.37 One organisation noted that it was not aware of either the GMC or the NMC generating publicity about the cases where fitness to practise sanctions were applied in connection with the duty of candour. Publicity around sanctions could set an example to other registrants.

5.38 In Appendix C of this report we have listed candour-related fitness to practise statistics relating to the GMC, NMC and other regulators.

Engaging with registrants and wider stakeholders

5.39 The GMC engages with its registrants in England through its Regional Liaison Service team who deliver sessions on candour. The sessions, developed with South London’s Health Innovation Network, cover both organisational and professional duties of candour, aiming to help professionals and organisations understand what they are required to do. The GMC has delivered 34 sessions in Scotland on raising concerns (which incorporates candour) and worked closely with the Scottish Government as it has introduced its organisational duty of candour. The GMC was praised by one professional body for delivering ‘useful’ workshops on its candour guidance. Related to the Scottish duty of candour, one educational organisation noted that the NMC and the HCPC collaborated with the

57 Between January 2015 and May 2018.
organisation and the Scottish Government to so support the launch of the duty of candour.

5.40 The PSNI, in response to the Hyponatremia Inquiry, published an article in its regulatory newsletter about the importance of the duty of candour in the context of the Inquiry’s findings.58 Candour was covered in the GOsC’s magazine, The Osteopath, in late 2014. The magazine explained the professional duty of candour, what was expected of registrants and work the GOsC was doing on candour.59 Since then, the GOsC has covered candour in the magazine in 2015, 2016 and 2018. When the HCPC revised its standards, making key changes related to the duty of candour, it relayed these changes through sending hard copies of the revised standards to every registrant, hosting tweetchats, publishing blog pieces and highlighting the changes in newsletters. The GPhC has published an article with case studies on good practice when making mistakes60 and a ‘reminder’ to the pharmacy profession of their duty to be open and honest in the wake of the February 2018 Bawa-Garba court decision.61 The GOC published an article in Optometry Today in 2018 explaining the professional duty of candour and how optometrists and dispensing opticians can apply it in practice.62

5.41 The GDC set up an advice line for dental professionals who needed support in raising an issue with a patient or about a colleague or other systemic issue. The line is hosted separately from the GDC by Public Concern at Work. The GDC told us that analysis of the available data shows that it is used by a range of registrant groups and that the majority of calls relate to patient safety issues.

5.42 The regulators have worked with stakeholders across health and social care to embed candour, for example, with system regulators. The NMC and the Care Quality Commission have a joint protocol which outlines the requirements of the duty of candour, how this relates to both healthcare professionals and providers, and how concerns can be raised with either regulator.63

5.43 The regulators have also worked with a broad range of stakeholders beyond regulation in order to embed candour. The NMC discussed that in order to draft its new standards for consultation and embed candour, it engaged with educators, education commissioners, academic education institutions, practice placement providers, students, service users, other professional bodies and registrants. The GMC has developed local relationships with which it can promote messages of candour and attempt to resolve concerns when there are local cultural issues, these relationships include Directors of Medical Education, Freedom to Speak Up Guardians, Health Education England and others. When consulting on including changes to its standards, some relating to candour, the HCPC engaged with educators, service users and carers, professional bodies and voluntary sector

59 General Osteopathic Council (2014). The Osteopath.
60 General Pharmaceutical Council (2017). Focus on responding and learning when things go wrong
61 General Pharmaceutical Council (2018). GPhC responds to concerns raised by pharmacy professionals in relation to the case of Dr Bawa-Garba
62 Optometry Today (2018). Being candid
organisations. Additionally, the HCPC noted that it raises the issue of candour at regular events it holds for employers.

5.44 The GOsC raised the issue of candour with the osteopathic professional body, the Institute of Osteopathy, which has included a reference to candour in its Patient Charter: ‘Your osteopath will be honest and open with you should anything go wrong while they are caring for you’.  

5.45 Finally, the GDC and the GOsC have jointly worked to understand patient and professional views on how the two groups can have better discussions and shared decision-making. Candid and full conversations can be useful to establish clear expectations for patients, which can be especially important when a treatment may have a cosmetic element and may involve significant costs. This joint work will contribute to the development of a toolkit.

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**Figure 5: Regulatory tools for understanding and encouraging candour**

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64 The Institute of Osteopathy, *The Patient Charter*
6. What more can regulators do to encourage candour?

6.1 Stakeholders and regulators had a variety of suggestions of how candour could be better encouraged across the health and care sector. For example, a complaints body noted that many people who bring their unresolved complaints about healthcare to the organisation, do so because they are dissatisfied with the local complaints response and are seeking an apology as an outcome. Therefore, the organisation suggested that there is perhaps more that healthcare providers and professionals can do to offer apologies promptly when something has gone wrong. Further suggestions about how non-regulatory organisations could encourage candour, include (in a non-exhaustive list):

- An improvement in the structure and working environment of clinicians to support clinicians who may work in a defensive culture and with high workloads
- Increased engagement by boards and Trusts with frontline staff in order to listen to their concerns
- Time set aside for professionals to reflect upon experiences and discuss and review those experiences with peers
- Insurers reducing insurance premiums for those who are candid and fining those who do not comply with the duty of candour.

6.2 However, this paper is focused on what professional regulation can do to encourage candour. The following chapter thematically organises those suggestions around how candour can be encouraged by professional regulators.

Case studies

6.3 A general theme emerging from the data we have collected is that candour is highly contextual; it is influenced by varying factors ranging from workplace cultures to inter-professional relationships. It was suggested by one participant that unless candour was anchored in the realities of professionals’ working lives it risked ‘just becoming another aspirational standard’. It was posited that case studies can demonstrate how the duty of candour could work in practice. The participant observed that case studies can be relatable and interesting for professionals as ‘people read stories about other people’ and that findings from real life cases tend to get more ‘hits’ online than rule-based guidance documents. The GCC pointed out there is too much guidance for professionals but that maybe some case studies, practical tools and resources are needed to ‘bring this issue [candour] to life’. It noted that this type of work had been well-received on the subject of conflicts of interest. It was also noted by discussion group participants that cases studies could be useful to communicate messages of candour to the public, as well as professionals.

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65 For example, Competing interests and incentives, GMC and Joint statement from the Chief Executives of statutory regulators of health and care professionals, NMC.
6.4 Additionally, one stakeholder mentioned that best practice should be shared as well as examples of when candour is not ‘delivered well’. There may even be a role for the Professional Standards Authority, as one participant suggested, to make use of its database by collating cases where candour has been an issue and looking at how they have been dealt with. Respondents noted there was potential for more use of positive examples of candour. The HCPC noted that positive examples of the benefits of candour to patients could help to more generally encourage candour.

6.5 We learnt earlier (paragraph 4.8) that a barrier to candour could be professionals lacking belief that being candid will have a meaningful outcome. Case studies with a positive outcome may help to alleviate this issue.

Patients and public

6.6 The HCPC’s patient-orientated suggestion at paragraph 6.4 is a significant one – when a professional is being candid there are usually two parties involved: professionals and patients. Much of the evidence in this paper has been oriented around the vantage point of professionals, with little focusing on patients’ perceptions of issues of candour. A firm of solicitors responding to our call for information, noted that patients often describe ‘feeling ignored or let down whilst struggling to access information regarding their treatment and it is this frustration which is often repeated upon solicitors’ first contact with clients’. Another firm observed that, although clinicians may admit to something going wrong in the care of a patient, they do not always provide enough details to answer all the patient’s questions, and patients are not given sufficient information to understand when negligence has occurred. It could be useful to better understand what patients think about candour, such as above, to better understand what patients want from candour.

6.7 One discussion group participant noted that training providers need to make professionals understand how the public feel when professionals have been candid. It was suggested by respondents that regulators could make use of patients’ and carers’ feedback in campaigns. It was also pointed out in questionnaire responses that practitioners should be made aware of the ‘positive impact on patients of early acknowledgment and communication of errors’. For example, the GOC’s guidance to its registrants notes the impact of an apology on patients: ‘Offering an apology is an important part of being candid as it shows that you recognise the impact of the situation on the patient and that you empathise with them’.66

6.8 One professional body considered it would be useful for the regulators to make the public aware that mistakes happen. This should also involve explaining that professionals attempt to minimise the risk of repeated errors.

Positive candour

6.9 When candour is discussed at the moment, it is frequently viewed from the negative vantage point of when a professional is lacking in candour. A significant number of questionnaire respondents and discussion group participants thought

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66 General Optical Council. *Candour guidance: Be candid when things have gone wrong*, paragraph 20.
there was an opportunity for regulators to focus more on when a professional has been candid to a patient, or ‘positive’ candour. One stakeholder noted:

‘We believe it would be counter-productive to emphasise the ‘stick’ of regulatory compliance by trying to place even greater importance on what regulators require when there is a rather more effective ‘carrot’ of educating professionals and explaining that being candid is an important part of their job and central to maintaining a professional relationship with patients’

6.10 Interestingly, the imagery of ‘stick’ was also used by three other organisations responding to the questionnaire and one discussion participant. The latter described fitness to practise as a ‘big blunt stick’ in encouraging candour amongst professionals. The discussion participant saw merit in regulators working more with education bodies and employers to encourage candour. A reshaping of the way candour is discussed could be useful in encouraging candour, as the GOsC puts it: ‘avoiding a discourse which is based around fitness to practise rather than seeing candour as a positive professional attribute’.

6.11 A number of stakeholders commented that when the duty of candour has a positive outcome there should be recognition of this, which can be shared widely. This can then be a positive learning experience not only for professionals but also for organisations. The GPhC was praised by one body for how its documentation of fitness to practise cases can promote learning but noted there was room for more positive stories. With the facts of these cases at their fingertips, pharmacists and pharmacy technicians can apply this to their own situations.

6.12 Although these comments emphasise that dialogue should move away from being based around fitness to practise in order to be more positive, fitness to practise does have some means to offer positive perspectives of candour. For example, in a fitness to practise hearing candour could be a mitigating factor which could be a case study for explaining the merits of candour to professionals. Discussion participants noted that there are limits to positive candour, in that weight attached to a candour mitigation would depend on the underlying facts of the case.

6.13 The ability to be candid should be seen as an important asset for professionals’ practice. Generally, healthcare professionals have a high level of trust amongst the public. However, this trust can easily disappear if honesty and openness is lacking. One firm of solicitors noted:

‘Many patients who contact us seeking legal advice regarding a potential negligence claim state that they had previously had a high level of confidence in their doctors (even when things may have gone wrong) but that it disappeared quickly in the absence of openness and honesty regarding their injury’

6.14 There may be merit in seeing candour as contributing to maintenance of public trust in professions. One regulator suggested that there should be ‘encouragement for seeing candour as a professional strength not a cause for concern’. Therefore, being a trusted professional should mean being expected to be candid.

6.15 Discussion group participants often returned to the need for the right balance in the regulatory response to cases involving candour. Although there was
widespread support amongst participants of positive steps to encourage candour by regulators, (through education and promotion at a local level), some participants discussed the role of fitness to practise proceedings in sending out a clear message to professionals and the public about the importance of being candid.

6.16 The GDC noted to us that it is committed to re-focusing its regulatory activities ‘upstream’ as set out in *Shifting the balance*. Part of this means promoting professionalism at an early stage in the careers of dental professionals, for example whilst they are still in education and training. As part of the work arising from *Shifting the balance*, the GDC has established an active programme of student engagement. As this programme develops, the student engagement will be part of a drive to promote professionalism and encourage candour. The GDC is also in the process of scoping a programme on ‘Promoting Professionalism’ to engage current registrants to embed the standards in their everyday practice and to encourage other organisations to use their influence on registrants to drive positive behaviour.

**Working with other organisations**

6.17 As we saw in the last chapter, regulators are limited in how much they can affect the candour of registrants. We received a number of suggestions of how regulators could work with other stakeholders. For example, candour could be better embedded and clarity increased about the two duties of candour by professional regulators working closely with system regulators. Working closely with system regulators could also include training for professionals and organisations to improve communications skills, enabling clinicians to have challenging conversations and dispelling fears about the legal ramifications of apologies.

6.18 We asked all organisations in the questionnaire ‘How does your organisation encourage professionals to behave candidly?’, the responses showed that a number of organisations beyond regulation have initiatives to encourage candour in individuals. For example, one educational body told us that it has developed an online learning module on the duty of candour, whilst a trade union described how it has delivered training to members and non-members on the statutory and professional duty of candour. There may be scope for regulators to learn from and work with other organisations providing advice on candour.

6.19 The GMC suggested it would be useful for ‘key players’ in the sector (regulators, employers, doctors) to work together to influence a cultural shift from ‘blame’ to ‘learning’, it noted that smaller behavioural changes such as improving communication skills of healthcare professionals can contribute to this culture change.

**Common approach of regulators**

6.20 One stakeholder considered it would be useful to have ‘one joined-up clear vision of candour’. Another organisation suggested that it would be timely for regulators to review and promote the joint statement of 2014 and consider how the statement

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67 General Dental Council (2017). *Shifting the balance: a better, fairer system of dental regulation*
could be more effectively disseminated and embedded. A separate organisation noted that its primary concern, regarding what regulators can do to further encourage candour, was that professionals should not find that compliance with the duty of candour leads to them facing arbitrary repercussions for exercising their duties. It welcomed a clear statement by professional regulators that this would not be the case.

6.21 Relatedly, the GOC considered that regulators had appeared recently to be working together more closely and this would help tease out new means of communicating the duty of candour to registrants. It went further and noted that collaboration between regulators could aid collective learning and that a ‘cohesive and collaborative approach’ on the part of regulators and stakeholders is required to allay concerns and encourage a cultural shift across the professions to be more candid. One professional body suggested that regulators can work collaboratively to better reflect the integrated and interprofessional contexts in which professionals work. It is also note that an educational organisation noted that consistency of applied thresholds for candour is ‘key across health and social care regulators’. Meanwhile, another stakeholder noted that given the current priorities around regulatory reform and regulators reviewing their processes, it would be essential for activity to be aligned to ‘outline a common set of care values and standards throughout the patient journey’.

6.22 One discussion group participant thought that collaboration between regulators ‘saves resources’ and that it may be useful to explore the idea of an interprofessional teaching module. Overall, discussion group participants viewed there to be many commonalities over candour between the regulators and room for more consistency and collaboration.

6.23 One membership body stakeholder told us that its members considered there to be a large volume and range of guidance on candour available. They noted the benefits of having a ‘single source of truth’ to ensure clarity of process is shared across professional groups. This echoes another stakeholder’s comment that it would be helpful to ‘have one joined-up clear version of candour’ across all regulators.

6.24 In 2014 we advised the Secretary of State that regulators should: ‘be encouraged to sign up to a joint statement declaring their support for and expectation that their registrants meet a professional duty of candour with a commitment to moving towards a common standard over time’. We noted then that a common standard ‘could help to redress some of the differences between the professions’ approaches to candour’. We still consider a common standard to be a useful means to encourage as it could help resolve tensions arising from divergent professional approaches, which may have an important contribution to multidisciplinary working. It might also provide an opportunity to clarify expectations and thresholds between the organisational and professional duty of candour.

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68 Professional Standards Authority (2013). Can professional regulation do more to encourage professionals to be candid when healthcare or social work goes wrong? Advice to the Secretary of State pp28-9.
Fitness to practise

6.25 Fitness to practise can be an opportunity for regulators to ‘emphasise that candour is not just a duty to be discharged, but a quality to be sought and valued’, suggested one professional body. It suggested that an act of candour should receive recognition when a professional is facing a sanction or being investigated. This echoes the comments earlier in this report of an educational body (paragraph 4.19) that suggested regulators have a role in ‘destigmatisation of those that disclose failings’. A few organisations considered that regulators could provide more clarity about how candour would be dealt with in fitness to practise processes. One organisation suggested regulators could do more to encourage candour by ‘providing clear guidance’ on what ‘factors will be considered’ when candour was dealt with in fitness to practise. Another organisation called for regulators to create guidance that gives professionals ‘a clear and rounded view of how regulators factor candour into their decisions’.

6.26 One stakeholder suggested that if a regulator receives a referral from an employer of a professional who has made an error, the regulator could take into account how much training, mentoring and other support the professional has received from their organisation, which can affect the professional’s levels of candour.

6.27 The NMC’s draft future fitness to practise strategy was viewed positively by one stakeholder, as it considered that the emphasis on context and taking into account whether an environment allows for reflection by a nurse or midwife could encourage better compliance with the duty of candour.

Guidance

6.28 In paragraph 5.9 we learnt that a stakeholder perceived there is a lack of specificity in the NMC code and guidance, which can mean it is harder for professionals to comply with the duty. The same professional body proposed that regulators and the Authority could make ‘clearer, less open-ended guidance so that health professionals have the confidence to comply that comes from clarity about the expectation on them’.

6.29 A professional body suggested that there needs to be more clarity on the relationship between ‘when something goes wrong’ and ‘distress in the professional duty of candour’. Currently, the joint statement says:

‘Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress’

6.30 The organisation pointed out that distress is a wide term and there is no clarification in the duty of candour about whether this should be assessed objectively (‘by reference to what a reasonable person would find distressing’) or subjectively. It also noted that distress can be caused by many factors in a healthcare environment, which may or may not be in the control of professionals. The organisation noted an example of this sort of difficulty, provided by one of its members:

‘Where an appropriate referral to hospital for further investigation results in the patient being told there is no problem, and the patient (who may
understandably have been distressed by the very act of referral) then demands an admission that the professional who made the referral has got things wrong."

6.31 The organisation noted that regulators’ guidance would be the appropriate vehicle to deal with this kind of scenario and ‘expand on what the regulators consider as amounting to distress which engages the duty of candour’. This example emphasises the potential helpfulness of using case studies.

**Education and training**

6.32 One stakeholder suggested that an outcome on understanding and applying principles of ‘courage, transparency and the duty of candour’ should be included in undergraduate learning in education institutions and practice placements. They said that this was because it is an ‘important foundation for embedding candour’ and pointed to the fact that the outcome is currently included in the NMC’s *Future Nurse: Standards of proficiency for Registered Nurses*. The same stakeholder also recommended that the HCPC should explicitly include ‘duty of candour’ in its Standards of Education and Training (SETs) so each health education institution is required to outline when this is covered and by what methods. It also suggested that this should link to the HCPC’s fitness to practise regulations and processes.

6.33 One education organisation called for education of the duty of candour to have a mandatory place in all health and social care professional education and training to be supported by professional regulators. It also noted that this should be delivered interprofessionally. It also noted that there should be interprofessional training sessions for students to make them aware of each other’s skills, knowledge and expertise. This could help students understand the value of all different professionals on a team, which can make them feel valued and thus have the confidence to be candid when they have qualified.

**Data**

6.34 One respondent recommended regulators could make more use of data to not only identify organisations that appear to have a high referral rate but also to raise issues with the system regulators for further investigation. Additionally, withstanding the limits of measuring candour through regulatory data, good use of data could help illustrate candour issues for professionals.

**Interprofessional working**

6.35 Stakeholders noted that there could be a role for different professional groups to work together to embed candour. One respondent organisation observed that receiving a complaint can be challenging and even distressing for a healthcare professional. The organisation noted that it had seen examples of NHS organisations addressing complaints received by individuals at multidisciplinary team meetings and working together to respond to these. By focusing on learning,

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70 Nursing and Midwifery Council (2018). *Future nurse: Standards of proficiency for registered nurses*

71 Standards of education and training. Standards against which the HCPC assesses education and training programmes.
rather than individuals and blame, this can offer a means to support and incentivise individuals to admit mistakes.

6.36 An educational organisation commented that ‘the increasing clinical model of multi-professional teams will need to be taken into account by regulators and employers’. Regulators may even have a role in fostering candour through interprofessional working. One education organisation suggested that professional regulators could work together to emphasise the need for interprofessional candour, noting that ‘where a mistake has been made by an interprofessional team the patient and family need to understand what has happened in a connected way and to receive information and support which reflects everyone in the team’.

6.37 Additionally, one professional body thought that it could be useful for the regulator relevant to their profession to reach out to other professional groups to ‘ensure candour is the responsibility of all professionals involved in patient care or service delivery’.
7. Conclusions

7.1 We have seen in this paper that the regulators have made wide-ranging efforts to embed candour. These include but are not limited to: introduction of candour-related standards, creation of candour guidance, inclusion of candour in fitness to practise documents and embedding candour in education and training. Regulators can both promote and encourage ‘positive candour’ and also express their disapproval where professionals have not been candid. As discussion participants suggested, regulators need to strike a balance in their approach to how they deal with candour.

7.2 There is much good practice by the regulators. Examples of good practice within this paper provide an opportunity for regulators to learn from each other. There may also be scope for regulators to collaborate more on candour to increase their effectiveness.

7.3 These positive examples could set out the benefits of being candid to patients. This paper has seen a few examples of when an organisation, not just regulators, explains why candour is a positive attribute. There are a range of benefits to patients from candour by professionals, for example an apology can foster ‘mutual trust and respect which forms the bedrock of the professional relationship’.\(^{72}\) We saw earlier that the GOC pointed out that an apology can show that a professional recognises the impact of the situation on a patient and that they empathise with the patient.\(^ {73}\) It has been suggested in other literature an apology can have ‘profound healing effects’ for professionals as well as patients as it can ‘help diminish feelings of guilt and shame’ in professionals in addition to facilitating forgiveness and create a foundation for reconciliation in patients.\(^ {74}\) One discussion participant talked about how the process of being candid has the capacity to be a ‘cathartic’ experience and can feel like a ‘weight lifted’.

7.4 It is difficult to work out how successful the regulators have been at encouraging candour given candour is hard to measure and the range of factors which affect a professional’s candour to patients – we discussed these issues in chapter 3. The views of stakeholders were mixed about the progress of regulators: some considered regulators to have made progress, others reflected that there had been little progress, whilst a number of stakeholders did not hold a view or found it difficult to attribute progress in embedding candour across health and social care to professional regulators.

7.5 Difficulty in understanding the effects of regulation is further tempered by the fact that it takes time to change cultures, as noted by a few organisations. One of these organisations said that regulators are limited by timescales for processes to ‘bed in and roll out’. It will take time to understand comprehensively the effects of changes to standards, education, fitness to practise and other areas.


\(^{73}\) General Optical Council. *Candour guidance: Be candid when things have gone wrong*, paragraph 20.

7.6 The paper has shown that although regulators have a role in encouraging and embedding candour, they are limited in their contribution. We suggest that it is necessary for organisations and individuals from across health and social care to work together to produce professionals who are candid to patients and work in environments that do not stymie that candour. Professionals need to, as discussion participants observed, ‘take candour to heart’. The encouragement of organisations across healthcare can enable that, making candour a professional strength to be valued, not just a regulatory requirement to be complied with. As one professional organisation noted in chapter 4: the duty of candour is ‘less to do with a culture of compliance and more to do with a culture of responsibility’. This paper has seen that regulators have relationships with key stakeholders, such as locally with employers and ‘upstream’ with education and training organisations. For candour to be embedded, regulators could further strengthen those relationships, working with and learning from other organisations working to encourage candour. For example, regulators working with employers and system regulators may help support trainees transitioning into the workforce to ensure positive reinforcement of skills learnt during training so they are not negatively impacted by environments with poor records of candour.

7.7 To summarise this paper, we make the following main conclusions:

- It would be useful to learn more about the benefits of candour from the perspectives of patients and different segments of the public.
- Many of the barriers to professionals being candid remain the same as in 2014 when we last did work in this area and the research we recommended has not been carried out.
- The capacity of individuals to be candid is highly influenced by the environment they work in. Influencers in that environment include the wider culture of an organisation, team members and non-clinical staff.
- Regulators have made progress with initiatives to encourage candour. However, measuring the success of these initiatives is difficult and no reliable method has yet been developed.
- There is support for more case studies of candour scenarios. This would help to better explain to professionals when to be candid and the regulatory consequences of not being candid.
- Candour does not appear in the determinations of regulators but they consider it is catered for in other charges like ‘dishonesty’. Most regulators do not have a category for it as an allegation type. Interprofessional working may help to create a culture of candour and candid professionals. Regulators could consider how they might use their role in quality assuring education to better enable interprofessional working.
- It may be useful for regulators to consider creating a ‘regulatory space’ in which professionals can be candid, this may be through tools such as consensual disposal and continuing fitness to practise.
- Issues of candour are shared across professions; there is scope for regulators to work together to solve these issues. A common standard applied across all
regulators could be a useful means to redress differences between professions over approaches to candour.

- Successful embedding of candour requires organisations across healthcare (not just regulators) to work together. Candour may be better embedded by regulators forging strategic relationships across the health and social care industry.

7.8 It is perhaps the last point that is the most critical for understanding regulation’s role in encouraging candour. This report has shown that there is not one way to embed a culture of candour, instead regulators, professional bodies, providers and education bodies need to work together.
8. Appendix A – Standards

8.1 Below are the standards of regulators, which are directly relevant to a professional when something has gone wrong in a patient’s care.\(^\text{75}\)

<table>
<thead>
<tr>
<th>Regulator</th>
<th>Standards relating to candour</th>
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<tr>
<td>GCC</td>
<td>B7. [You must] Fulfil the duty of candour by being open and honest with every patient. You must inform the patient if something goes wrong with their care which causes, or has the potential to cause, harm or distress. You must offer an apology, a suitable remedy or support, along with an explanation as to what has happened.(^\text{76})</td>
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| GDC       | 1.3.1 You must justify the trust that patients, the public and your colleagues place in you by always acting honestly and fairly in your dealings with them. This applies to any business or education activities in which you are involved as well as to your professional dealings.  
2.2.3 You must give full and honest answers to any questions patients have about their options or treatment.  
5.3.8 You should offer an apology and a practical solution where appropriate.\(^\text{77}\) |
| GMC       | You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:  
   a. put matters right (if that is possible)  
   b. offer an apology  
   c. explain fully and promptly what has happened and the likely short-term and long-term effects.\(^\text{78}\) |
| GOC       | Optical professionals 19. Be candid when things have gone wrong  
19.1 Be open and honest with your patients when you have identified that things have gone wrong with their treatment or care which has resulted in them suffering harm or distress or where there may be implications for future patient care. You must:  
19.1.1 Tell the patient or, where appropriate, the patient’s advocate, carer or family) that something has gone wrong.  
19.1.2 Offer an apology. |

\(^\text{75}\) We note that regulators may also have additional standards which deal with contributing to a workplace where professionals can be open. For example, the GDC’s ‘8.3.1 You must promote a culture of openness in the workplace so that staff feel able to raise concerns’.

\(^\text{76}\) GCC. *The Code Standards of conduct, performance and ethics for chiropractors*

\(^\text{77}\) GDC. *Standards for the Dental Team*

\(^\text{78}\) GMC. *Domain 4: Maintaining trust*
19.1.3 Offer appropriate remedy or support to put matters right (if possible).
19.1.4 Explain fully and promptly what has happened and the likely short-term and long-term effects.
19.1.5 Outline what you will do, where possible, to prevent reoccurrence and improve future patient care.

19.2 Be open and honest with your colleagues, employers and relevant organisations, and take part in reviews and investigations when requested and with the General Optical Council, raising concerns where appropriate. Support and encourage your colleagues to be open and honest, and not stop someone from raising concerns.

19.3 Ensure that when things go wrong, you take account of your obligations to reflect and improve your practice as outlined in standard 5. [keeping knowledge and skills up to date]79

*Optical students* 18. Be candid when things have gone wrong

18.1 Be open and honest with your patients when you have identified that things have gone wrong with their treatment or care which has resulted in them suffering harm or distress or where there may be implications for future patient care, seeking advice from your tutor or supervisor on how to proceed. They will advise on whether further action is required such as:

18.1.1 Telling the patient (or, where appropriate, the patient’s advocate, carer or family) that something has gone wrong.
18.1.2 Offering an apology.
18.1.3 Offering appropriate remedy or support to put matters right (if possible).
18.1.4 Explaining fully and promptly what has happened and the likely short-term and long-term effects.
18.1.5 Outlining what you will do, where possible, to prevent reoccurrence and improve future patient care. 18.2 Be open and honest with your supervisor or training provider and take part in reviews and investigations when requested and with the General Optical Council, raising concerns where appropriate. Support and encourage your peers to be open and honest, and not stop someone from raising concerns.

18.3 Ensure that when things go wrong, you reflect on what happened and use the experience to improve.

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79 GOC. *Standards of Practice for Optometrists and Dispensing Opticians*
| **GOsC** | **D3. You must be open and honest with patients, fulfilling your duty of candour.**

1. If something goes wrong with a patient’s care which causes, or has the potential to cause, harm or distress, you must tell the patient, offer an explanation as to what has happened and the effects of this, together with an apology, if appropriate, and a suitable remedy or support.

2. You must also be open and honest with your colleagues and/or employers, where applicable, and take part in reviews and investigations when requested. |

| **GPhC** | **Standard 8: People receive safe and effective care when pharmacy professionals:**

- promote and encourage a culture of learning and improvement
- challenge poor practice and behaviours
- raise a concern, even when it is not easy to do so
- promptly tell their employer and all relevant authorities (including the GPhC) about concerns they may have
- support people who raise concerns and provide feedback
- are open and honest when things go wrong
- say sorry, provide an explanation and put things right when things go wrong
- reflect on feedback or concerns, taking action as appropriate and thinking about what can be done to prevent the same thing happening again
- improve the quality of care and pharmacy practice by learning from feedback and when things go wrong. |

| **HCPC** | **8.1 You must be open and honest when something has gone wrong with the care, treatment or other services that you provide by:**

- informing service users or, where appropriate, their carers, that something has gone wrong;
- apologising;
- taking action to put matters right if possible; and
- making sure that service users or, where appropriate, their carers, receive a full and prompt explanation of what has happened and any likely effects. |

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80 GOsC. [Osteopathic Practice Standards](#)

81 GPhC. [Standards for pharmacy professionals](#)

82 HCPC. [Standards of conduct, performance and ethics](#)
| **NMC** | **14** Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place  
To achieve this, you must:  
14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm  
14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers, and  
14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly.83 |
| **PSNI** | **Standard 1.2:** Uphold the duty of candour and raise concerns appropriately  
1.2.4 When something goes wrong with a pharmacy service, explain fully to the patient or service user what has happened, and where appropriate:  
• offer an apology  
• offer an appropriate and effective remedy  
• explain the short and long term effects  
• provide support and assist to put matters right.  
1.2.5 Be open and honest with patients, service users, colleagues, and employers when something goes wrong.84 |

83 NMC. *The Code Professional standards of practice and behaviour for nurses and midwives*  
84 PSNI. *The Code: Professional standards of conduct, ethics and performance for pharmacists in Northern Ireland*
9. Appendix B – Standards for education and training providers

9.1 The table below shows candour specific standards of five regulators for education and training providers.

<table>
<thead>
<tr>
<th>Regulator</th>
<th>Education standards relating to candour</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCC</td>
<td>1.3. Recognise, understand and describe specific legislation relevant to the work of chiropractors, including ionising radiation. Guidance: This would normally include […] duties imposed by law, such as the Duty of Candour. 6 Demonstrate an understanding of the nature of professional accountability. Guidance: This would normally include the ability to[…]fulfil the duty of candour.85</td>
</tr>
<tr>
<td>GDC</td>
<td>6. Providers must ensure that students and all those involved in the delivery of education and training are aware of their obligation to raise concerns if they identify any risks to patient safety and the need for candour when things go wrong.86</td>
</tr>
<tr>
<td>GMC</td>
<td>R1.4 Organisations must demonstrate a learning environment and culture that supports learners to be open and honest with patients when things go wrong – known as their professional duty of candour – and help them to develop the skills to communicate with tact, sensitivity and empathy.87</td>
</tr>
<tr>
<td>NMC</td>
<td>At the point of registration, the registered nurse will be able to: 1.3 understand and apply the principles of courage, transparency and the professional duty of candour, recognising and reporting any situations, behaviours or errors that could result in poor care outcomes88 Approved education institutions, together with practice learning partners, must: 1.9 ensure students are supported and supervised in being open and honest with people in accordance with the professional duty of candour89</td>
</tr>
</tbody>
</table>

85 GCC (2017). Education Standards: Criteria for chiropractic programme content and structure
86 GDC (2015). Standards for Education Standards and requirements for providers
87 GMC. Promoting excellence: standards for medical education and training
<table>
<thead>
<tr>
<th>GPhC</th>
<th>Pre-registration trainee pharmacy technicians will:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>‘22. Act openly and honestly when things go wrong’\textsuperscript{90}</td>
</tr>
</tbody>
</table>

\textsuperscript{90} GPhC (2017). \textit{Standards for the initial education and training of pharmacy technicians.}. 
10. Appendix C – Fitness to practise statistics

10.1 We asked regulators: ‘How frequently do you receive fitness to practise complaints/referrals about candour failures? What proportion of these is closed in the earlier stages of your FtP process (ie. any stage before the final hearing stage)?’. The GOsC, GPhC, HCPC and PSNI did not produce data in response. This was for a range of reasons: no data available, categorisation does not cater for candour or no complaints or referrals relating to candour. The HCPC noted that it is currently developing its approach to case categorisation, and hopes to include categories such as: ‘failure to be open and honest’; ‘failure to recognise or report concerns promptly or appropriately’; and ‘failure to support, follow up or escalate concerns’.

GCC

Investigating Committee

10.2 The GCC does not have a specific category for ‘candour’ within its categorisation methods, as the word ‘candour’ may take in various issues that may form a complaint.

Professional Conduct Committee

10.3 In 2017, one PCC case related specifically to issues of candour. It is described in the footnote.  

GDC

10.4 The GDC does not have an explicit standard against which issues around candour are considered. It has looked at data under the standard ‘Put patients’ interests first’, then under ‘not acting honestly and fairly with patients’:

<table>
<thead>
<tr>
<th>Decision date</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018 Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>95</td>
<td>83</td>
<td>136</td>
<td>130</td>
<td>45</td>
</tr>
</tbody>
</table>

GMC

10.5 The GMC told us that there have been at least of 322 complaints (see table below) received since 2014 (to 2017 inclusive) where there has been an allegation in

---

91 It was found proved by the PCC that the registrant had burnt the patient using a specific technique, known as ‘cupping’. The Committee then determined that if the registrant knew that he had burnt the patient then he was under a duty to inform the patient of this. The Committee noted that the registrant said that he told the patient that he had singed his hairs, but concluded that his duty, at that stage, was not to attempt to minimise what had occurred but to give the patient a proper explanation of what had occurred. The Committee was satisfied that he did not do so. The Committee was satisfied that the registrant had failed to take even the most basic steps to minimise the extent of the burn and had said words to the effect of “…that’s nothing, put burn spray on it” and “you don’t need to go to hospital”. The Committee concluded that the only potential breach of the Code was a breach of B7 (duty of candour) in that the registrant had not been as candid with the patient as he should have been. This case did not, however, lead to a finding of unacceptable professional conduct.
relation to duty of candour relating to paragraphs 23, 24 and 55 of Good Medical Practice 2013. The GMC only started recording allegations against enquiries closed at the triage stage in January 2017 and therefore allegations in relation to the duty of candour that were closed at the triage stage prior to 2017 are not captured below. This explains the significant increase in total complaints relating to the duty of candour in 2017.\(^\text{92}\)

<table>
<thead>
<tr>
<th>Year of receipt of complaint</th>
<th>Total</th>
<th>Closed at triage</th>
<th>Closed at investigation</th>
<th>Advice</th>
<th>Warning</th>
<th>Undertaking</th>
<th>Refer to tribunal</th>
<th>In progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>83</td>
<td>-</td>
<td>60</td>
<td>13</td>
<td>1</td>
<td>-</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>2015</td>
<td>56</td>
<td>-</td>
<td>41</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2016</td>
<td>36</td>
<td>-</td>
<td>19</td>
<td>6</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2017</td>
<td>147</td>
<td>92</td>
<td>35</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>322</td>
<td>92</td>
<td>155</td>
<td>24</td>
<td>4</td>
<td>6</td>
<td>10</td>
<td>31</td>
</tr>
</tbody>
</table>

**GOC**

10.6 The GOC told us that: ‘when opening an investigation, documents the primary and secondary standards that are potentially breached in a fitness to practice case. A failure to comply with their professional obligation to be candid could be measured using this data, for example since 1 April 2016, there are’:

**Optometrists and Dispensing Opticians**
- 7 out of 3912 cases have Standard 19 for as the primary standard breached
- 4 out of the 7 cases were self-referrals
- 1 case was in relation to misconduct (a summary of this case can be found at Question 7, case 2)
- 15 out of 3912 cases have Standard 19 for as the secondary standard breached
- 1 out of the 93 cases were self-referrals.

**Student Optometrists and Dispensing Opticians**
- 1 out of 3912 cases have Standard 18 as the primary standard breached
- 3 out of 3912 cases have Standard 18 as the secondary standard breached
- None of these cases were self-referrals.

\(^{92}\) The GMC further noted that the data above is correct as of 3 May 2018. Cases may have additional allegations added that relate to duty of candour up to the point of closure and therefore these figures are subject to change if new allegations are identified. The total is the minimum number received as the GMC only started recording allegations against enquiries from January 2017 and therefore enquiries related to duty of candour closed at triage prior to 2017 are not captured here.
10.7 In January 2017 the NMC introduced an allegations coding framework, which specifically includes codes relating to candour. Prior to January 2017 it was not possible to capture this data in a systematic way. The NMC’s data on decisions and allegations coded at Case Examiner (CE) stage for the period of 1 April 2017 – 31 March 2018 is shown below. The following tables provide a breakdown of duty of candour CE decisions.

**Table 1. Duty of Candour allegations and case examiner decisions**

<table>
<thead>
<tr>
<th>CE decision</th>
<th>Total</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case to Answer</td>
<td>322</td>
<td>47</td>
</tr>
<tr>
<td>No Case to Answer</td>
<td>370</td>
<td>53</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>692</strong></td>
<td><strong>-</strong></td>
</tr>
</tbody>
</table>

**Table 2. Duty of Candour allegations that were case to answer decisions**

<table>
<thead>
<tr>
<th>CE decision</th>
<th>Case total</th>
<th>Allegation total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to Fitness to Practise Committee</td>
<td>319</td>
<td>501</td>
</tr>
<tr>
<td>Recommend undertakings</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>322</strong></td>
<td><strong>504</strong></td>
</tr>
</tbody>
</table>

**Table 3. Duty of Candour allegations that were no case to answer decisions**

<table>
<thead>
<tr>
<th>CE decision</th>
<th>Case total</th>
<th>Allegation total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No case to answer</td>
<td>322</td>
<td>398</td>
</tr>
<tr>
<td>Warning issued</td>
<td>44</td>
<td>61</td>
</tr>
<tr>
<td>Advice issued</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>370</strong></td>
<td><strong>466</strong></td>
</tr>
</tbody>
</table>

10.8 Between the introduction of allegation coding in January 2017 and March 2018, 449 cases were identified with a total of 566 duty of candour allegations. Of the cases, 345 cases resulted in a sanction. The table below summarises the number of cases and the number of allegations by sanction. A more detailed breakdown of outcomes by allegation can be found in table 5.

**Table 4. Case outcomes by sanction**

<table>
<thead>
<tr>
<th>Sanction</th>
<th>Case total</th>
<th>Allegation total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fitness to Practise impaired – striking off order</td>
<td>163</td>
<td>216</td>
</tr>
</tbody>
</table>

---

93 The NMC notes that due to the coding and how this data is collected, it may include additional allegations that have not involved breaches of the legal duty of candour, but more general failures to be candid, either with patients, employers or the regulator. The data is based on CE decision data, not referral rate, and therefore may contain a number of referrals made to the NMC prior to January 2017. The NMC does not hold complete allegations data for cases closed at screening in 2017.
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Allegation level one</th>
<th>Allegation level two</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>FtP Impaired – striking off order</td>
<td>Dishonesty</td>
<td>Employment related dishonesty</td>
<td>105</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient care related dishonesty</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>NMC registration and proceedings</td>
<td>Not disclosing NMC investigation to employer</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not notifying NMC of criminal proceedings</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not cooperating with NMC investigation</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Employment and contractual issues</td>
<td>Collusion to cover up information</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Management issues</td>
<td>Not reporting incidents and complaints</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Communication issues</td>
<td>Not abiding by duty of candour</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not giving full or right information to patients and families</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Investigations by other bodies</td>
<td>Not cooperating with other investigations by healthcare regulator</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not cooperating with other formal investigations</td>
<td>1</td>
</tr>
<tr>
<td>FtP impaired – suspension order</td>
<td>Dishonesty</td>
<td>Employment related dishonesty</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient care related dishonesty</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>NMC registration and proceedings</td>
<td>Not cooperating with NMC investigation to employer</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not notifying NMC of criminal proceedings</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Communication issues</td>
<td>Not giving full or right information to patients and families</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not abiding by duty of candour</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Management issues</td>
<td>Not reporting incidents and complaints</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Employment and contractual issues</td>
<td>Collusion to cover up information</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Investigations by other bodies</td>
<td>Not cooperating with other formal investigations by healthcare regulator</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not cooperating with other investigations by healthcare regulator</td>
<td>1</td>
</tr>
<tr>
<td>FtP impaired –</td>
<td>Dishonesty</td>
<td>Employment related dishonesty</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient care related dishonesty</td>
<td>19</td>
</tr>
<tr>
<td>Management issues</td>
<td>Not reporting incidents and complaints</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>caution order</td>
<td>NMC registration and proceedings</td>
<td>Not cooperating with NMC investigation Not disclosing NMC investigation to employer Not notifying NMC of criminal proceedings</td>
<td>3 3 1</td>
</tr>
<tr>
<td>Communication issues</td>
<td>Not giving full or right information to patients and families</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Investigations by other bodies</td>
<td>Not cooperating with other formal investigations</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Employment and contractual issues</td>
<td>Collusion to cover up information</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>FtP impaired – conditions of practice order</td>
<td>Communication issues</td>
<td>Not giving full or right information to patients and families Not abiding by duty of candour</td>
<td>5 2</td>
</tr>
<tr>
<td>Dishonesty</td>
<td>Patient care related dishonesty Employment related dishonesty</td>
<td>10 6</td>
<td></td>
</tr>
<tr>
<td>Investigations by other bodies</td>
<td>Not cooperating with police investigations Not cooperating with other formal investigation</td>
<td>2 1</td>
<td></td>
</tr>
<tr>
<td>NMC registration and proceedings</td>
<td>Not disclosing NMC investigation to employer Not cooperating with NMC investigation</td>
<td>1 1</td>
<td></td>
</tr>
<tr>
<td>Management issues</td>
<td>Not reporting incidents and complaints</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Grand total</td>
<td></td>
<td>439</td>
<td></td>
</tr>
</tbody>
</table>
11. Appendix D - Stakeholders who responded to questionnaires

Action Against Medical Accidents
Association of British Dispensing Opticians
Association of Optometrists
Barratts
British Dental Association
Care Quality Commission
Centre for Advancement of Interprofessional Education
Conference of Postgraduate Medical Deans
Faculty of Pharmaceutical Medicine
Good Clinical Practice Alliance – Europe
Health Education Improvement Wales
Hywel Dda University Health Board
Lincolnshire Partnership NHS Foundation Trust
Medical Schools Council
Medical Defence Union
NHS Education for Scotland
NHS Employers
NHS Resolution
Parliamentary and Health Service Ombudsman
Pharmacy Forum Northern Ireland
Royal College of Anaesthetists
Royal College of Emergency Medicine
Royal College of Nursing
Royal College of Paediatrics and Child Health
Royal College of Physicians of Edinburgh
Royal College of Physicians and Surgeons of Glasgow
Royal College of Physicians
Royal College of Surgeons
Royal College of Surgeons of Edinburgh
Royal Pharmaceutical Society
Unite the Union
Unison
Scottish Public Services Ombudsman
Social Care Wales
Strategic Initiative for Developing Capacity in Ethical Review
Waldrons Solicitors
Plus 11 individual members of the public and 4 organisations who did not want to be attributed.

Professional Standards Authority for Health and Social Care
157-197 Buckingham Palace Road
London SW1W 9SP

Email: michael.warren@professionalstandards.org.uk
Website: www.professionalstandards.org.uk
Telephone: 020 7389 8030
1. Purpose
The purpose of this report is to provide an update to Council on the current performance of the Fitness to Practise department.

2. Action required
Council is asked to note the report.

3. Financial implications
There are no financial implications arising from this paper

4. Legal or Risk Implications
There are no legal or risk implications arising from this paper

5. Equality Implications
There are no equality implications arising from this paper

6. Communications Implications
There are no communications implications arising from this paper.
Key Performance Indicators (reported by exception)

<table>
<thead>
<tr>
<th>Fitness to Practise</th>
<th>Status</th>
<th>Exception Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>To determine Investigation Committee (IC) cases within a median target of 28 weeks from receipt of the complaint to determination by the IC.</td>
<td></td>
<td><strong>Actual rate (as at 1 March 2019)</strong>&lt;br&gt;The median target for cases determined by the IC for the last 12 months is <strong>29 weeks</strong>. The mean of IC cases for the same period is <strong>31 weeks</strong></td>
</tr>
</tbody>
</table>

The KPI of 28 (median) weeks is not currently met for IC determinations.

Four of the five cases that were closed at the February 2019 IC meeting were over the 28 week target which affected performance from 27 weeks (rolling average) at the start of February to 29 weeks at the start of March. It is expected that this is a temporary phenomenon and performance against the KPI will improve - given the number of current live cases open for less than 28 weeks - the current median for open IC cases is 12 weeks. In other words, the rolling average KPI is somewhat volatile. See also table below.

<table>
<thead>
<tr>
<th>Length of time since complaint received/case opened</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 13 weeks</td>
<td>31</td>
<td>55%</td>
</tr>
<tr>
<td>13 – 26 weeks</td>
<td>14</td>
<td>25%</td>
</tr>
<tr>
<td>26 – 39 weeks</td>
<td>6</td>
<td>11%</td>
</tr>
<tr>
<td>39 – 52 weeks</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>52 – 104 weeks</td>
<td>4</td>
<td>7%</td>
</tr>
<tr>
<td>104 – 152 weeks</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>152 weeks +</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>56</td>
<td>100%</td>
</tr>
</tbody>
</table>

We have had an unexpected rise in complaints received in the first two months of the year. In January and February we received 21 complaints for consideration. This is the highest number for the period in the last five years:

- Jan – Feb 2015 – 9 cases received
- Jan – Feb 2016 – 8 cases received
- Jan – Feb 2017 – 10 cases received
- Jan – Feb 2018 – 13 cases received
- Jan – Feb 2019 – 21 cases received

We are not clear on any specific cause for the increase in the volume of complaints.

The current live cases at IC are progressing; however the increase in new cases has put additional pressure on the team. There has been a 33% increase in caseload since the
beginning of the year. It is also important to note that in December 2018, eight cases (the highest amount in one month for 2018) were received.

### Caseload 2019

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of cases at start of the month</td>
<td>42</td>
<td>47</td>
<td>56</td>
</tr>
<tr>
<td>Number of new cases received in month</td>
<td>7</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Number of cases determined in month</td>
<td>2</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Number of cases at the end of the month</td>
<td>47</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>% cumulative change in caseload since start of year (at the end of the month)</td>
<td>+12%</td>
<td>+33%</td>
<td></td>
</tr>
<tr>
<td>Number of IC days</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Total Cases Considered</td>
<td>2</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

### IC Determinations

There have been seven IC determinations in the first 2 months of 2019.

Of these, six cases were determined as a no case to answer. There was one referral to the Professional Conduct Committee which represents a referral rate of 14%.

### Decisions

<table>
<thead>
<tr>
<th></th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Case to Answer</td>
<td>6 86%</td>
</tr>
<tr>
<td>Referred to PCC</td>
<td>1 14%</td>
</tr>
</tbody>
</table>

### Professional Conduct Committee (PCC) caseload

There has been no change in the amount of live PCC cases in 2019, to date. There were seven cases live at the start of the year, one has been concluded by the PCC and one has been referred from the IC.

<table>
<thead>
<tr>
<th></th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of PCC cases at start of month</td>
<td>7</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>New Referrals from the IC</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>PCC Cases Closed</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
Advertising cases progress

Advertising cases are progressing well.

225 cases have now been closed with no case to answer. There are 68 cases remaining which will be considered at the final three weeks of IC meetings. In the event that there are cases outstanding (adjournments) after the three weeks, we have taken the step of scheduling now six days of meetings for May 2019. All being well we are looking for this exercise to conclude in May 2019, at the conclusion of these cases.

<table>
<thead>
<tr>
<th>Number of cases closed by IC with the following outcomes</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No case to answer</td>
<td>225</td>
<td>74%</td>
</tr>
<tr>
<td>Referred to PCC</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Number of cases remaining</td>
<td>68</td>
<td>22%</td>
</tr>
<tr>
<td>Number of cases closed pre-IC (Duplications, errors etc.)</td>
<td>13</td>
<td>4%</td>
</tr>
</tbody>
</table>

**TOTAL** 306 100%

Section 32 progress

External resources have been engaged to assist with the open Section 32 cases. These are progressing well.

All but one of the section 32 cases have now been reviewed.

Active cases will now be prioritised with a view to moving towards closure or closure with guidance.

<table>
<thead>
<tr>
<th>Section 32 cases</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live section 32 cases</td>
<td>107</td>
</tr>
<tr>
<td>Cases closed with no further action</td>
<td>36</td>
</tr>
<tr>
<td>Cases closed with ‘guidance’ letter</td>
<td>9</td>
</tr>
<tr>
<td>Cases with GCC to consider for closure</td>
<td>2</td>
</tr>
<tr>
<td>Cases under review/active</td>
<td>59</td>
</tr>
<tr>
<td>Cases not yet reviewed as part of s.32 secondment</td>
<td>1</td>
</tr>
</tbody>
</table>
1. Purpose

The purpose of this paper is to provide Council with an update on progress in delivering the GCC’s 2019 Business Plan. Progress update reports will be presented at each meeting of the Council.

2. Background

The new GCC five-year strategy was agreed by Council in December 2018. There are four strategic aims:

- We promote standards
  
  *We will set, assure compliance and promote educational, professional & registration standards alongside lifelong learning*

- We develop the profession
  
  *We will facilitate collaborative strategic work to support the profession in its development*

- We investigate and act
  
  *We will take right touch action on complaints, the misuse of title or where registration standards are not met*

- We deliver value
  
  *We will be a great place to work, work together and deliver effective /efficient services*

The Business Plan for 2019 is the plan for delivering the first year’s objectives and is an ambitious programme of work for 2019. It comprises 27 projects this year. Most projects have dependencies with others whilst some are discrete, and therefore simpler to deliver. In essence, it is our change programme.

A senior management team has been formed and programme progress is reported to the weekly meeting of the team. In addition we have established a fortnightly programme board group with colleagues involved in delivering the projects. There is a balance to be struck between oversight, and ensuring teams have the space to take forward the work – particularly in a small organisation like ours. We see the programme board as a supportive forum for discussion and developing ideas rather than an unrelenting account-holding forum. This report provides an update on progress, which has largely been around clarifying and establishing scope; ensuring that we have a focus on ‘purpose’ and that a clear definition of benefits emerges for each, such that we can subsequently measure or assess that those benefits have been realised from – what in some cases – will be substantial inputs. A table of all projects is at Annex A.
3. We promote standards

We will set, assure compliance and promote educational, professional & registration standards alongside lifelong learning

Desired outcomes:
- Registrants are able to demonstrate their continued competence that reflects their development steps through the continuous professional development (CPD) arrangements
- Chiropractic education of a good quality in a sufficient number, ensuring it meets the needs of students and the profession
- Relevant and meaningful standards of registration promoting high quality care
- Confidence in the chiropractic profession by the public

4. Current status

Development of a revised approach to CPD submissions and how we check the quality of those submissions is currently underway:

- We are engaged in a process of engagement with educational institutions, professional associations and others – with a focus on the CPD scheme.
- The Education Committee meeting in April is receiving feedback from education providers and Anna Van de Gaag, a prior chair of the HCPC and specialist in healthcare regulation will be facilitating discussion around a revised approach to CPD evidence gathering.
- Consultation with stakeholders will then feed in to further consideration by Council at its June 2019 meeting.

We will seek insights from education providers in our engagement:

- The development of a strategy for student engagement will be considered by Education Committee at its meetings in April and July 2019.
- Teesside University has confirmed its intention to commence a new chiropractic programme in September 2020, and work will continue through 2019 to facilitate this.
- Joint research and collaborative work with GOsC is underway with workshops attended by chiropractors and osteopaths in progress. A publicity campaign on the benefits of seeing a registered chiropractor will begin later in the year – and our thinking is that this will be aligned to the development of our new website, social media and other communication channels.

5. We develop the profession

We will facilitate collaborative strategic work to support the profession in its development

Desired outcomes:
- Enhanced identity and reputation for the profession
- Increased evidence base for chiropractic care
- More recognition for the profession in the wider/national health and well-being system
- Better care for patients as a result of new guidance
6. Current status

- Collaborative work with the professional associations has begun towards creating a clearer identity for the profession. This will feed into the creation of specific projects with the professional groups later in the year.
- Following the completion of the ‘advertising cases’ we will want to undertake a thorough ‘lessons learned’ review and report - to create more resilient operational arrangements in the future. Consideration of how we contribute to the collection and review of baseline data on workforce, education planning and diversity/inclusion is planned.
- Work to co-ordinate the collation of a baseline of current work and plans to further develop research and governance and to further develop research and governance has yet to start.

7. We investigate and act

*We will take right touch action on complaints, the misuse of title or where registration standards are not met*

Desired outcomes:
- The safety of patients
- The public and registrants are clear as to ‘chiropractor’ as a title
- The public, students and registrants are clear about the standards in place that registrants must meet. Information from our analysis of complaints, and dissemination of this knowledge on a regular basis will support registrants in preventing concerns arising.

8. Current status

Reassessing our Fitness to Practise (FtP) processes, facilitating a ‘right touch’ approach enables us to provide better assurance that appropriate action will be taken when we receive complaints.

- Process maps of the current ‘as is’ FtP process are complete.
- Review meetings to test out refined processes involving the core team will be carried out over the next few weeks

Work has started on setting our registration standards frameworks, including those on good character and health. The new frameworks will ensure consistency in decision making across the organisation.

9. We deliver value

*We will be a great place to work, work together and deliver effective /efficient services*

Desired Outcomes:
- A new GCC website
- More effective, streamlined procedures for registrants and GCC staff
- Communication, engagement and collaboration will build confidence and trust
- Improved culture, values and people development
- Financially secure
10. Website

A big project for us this year is the launch of a new website. Our current website is out-dated, not user-friendly or responsive and has poor accessibility and does not facilitate efficient processes for registrants or for the GCC team.

- An audit report and recommendations were provided by an IT consultant in 2018
- Collaborative scoping work has begun to define key outcomes and benefits that the GCC expect from a new website. We will seek Council involvement and decisions (possibly outside the usual meeting cycle) given its centrality to our change ambitions
- We are engaging with providers and the process is underway

11. Registrations process and new database

We must streamline our registration processes to benefit registrants and our team. It is intended that as much of our registration processes as possible are moved into a self-service model online:

- ‘As is’ process maps have been produced
- Requirements for a new registrations database system have been sent to our current database provider and a proposal has been provided.
- Due diligence has been undertaken
- A system demonstration session has been attended by staff

The business plan specified July as a delivery date, which now looks ambitious, given technical and information migration arrangements (from the current to new database). Whilst completion is probable ‘this year’ we are currently engaged in testing all assumptions to bring forward. Council is asked to note the risks to timescales here.

12. Communication and engagement

Our communication agency, Barley, continue to work with us on a range of communication/engagement initiatives including our new newsletter for registrants and stakeholders during 2019.

- We will increase our social media usage, particularly using twitter as a vehicle, for regularly publishing shared learning and intelligence from the work we, and other regulators, do.

13. Our people

Work has been taking place since 2018 to refresh our HR approach

- Implementation of an updated staff handbook is underway
- Reviews of all our HR policies is nearing completion and will be launched with the new handbook and the completion of a new self-serve HR system (for recording leave, holding job descriptions; objectives, performance appraisals and so on) by end-April 2019
- A staff survey is planned subsequently to establish a baseline of staff satisfaction
- A new approach to objective setting, performance review and personal development will be implemented alongside this.
14. Action required

Council is asked to note the content of the report, comment, engage and be involved in future work that arises from this.

15. Financial implications

There are financial implications arising from this paper, accounted for in the budget. The largest cost implications will be in relation to the new website and new database system.

16. Legal or Risk Implications

There are legal implications arising from this paper, particularly in relation to process reviews within the FtP and Registrations departments. Legal advice may be required to make sure any proposed process changes remain within our current legislative rules. There are risk implications arising from this paper. There may be projects that are unable to meet allocated timeframes due to external influences.

17. Equality Implications

There are equality implications arising from this paper. Full process reviews, changes to education standards and implementation of a new website and database system may require equality impact assessments.

18. Communications Implications

There are communications implications arising from this paper. There are increased opportunities to engage with all of our stakeholders as part of the programme work.
## WE PROMOTE STANDARDS

*We will set, assure compliance and promote educational, professional & registration standards alongside lifelong learning*

<table>
<thead>
<tr>
<th>Ref. No.</th>
<th>Business plan activity</th>
<th>Timescale</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Complete qualitative research (in partnership with GOsC) into the role of patients in chiropractic education and agree an action plan</td>
<td>November</td>
<td>Delayed</td>
</tr>
<tr>
<td>2</td>
<td>Develop and agree a strategy for student engagement</td>
<td>November</td>
<td>On track</td>
</tr>
<tr>
<td>3</td>
<td>Provide support to current and emerging new providers throughout 2019</td>
<td>Ongoing</td>
<td>Ongoing</td>
</tr>
<tr>
<td>4</td>
<td>Refine our new quality assurance processes and procedures to ensure they are effective and efficient throughout 2019</td>
<td>Ongoing</td>
<td>Future task</td>
</tr>
<tr>
<td>5</td>
<td>Facilitate agreement on a plan of work to enable the profession/chiropractors to better support newly qualified chiropractors</td>
<td>December</td>
<td>Future task</td>
</tr>
<tr>
<td>6</td>
<td>Develop and implement a proportionate approach to CPD submissions and audit</td>
<td>September</td>
<td>On track</td>
</tr>
<tr>
<td>7</td>
<td>With GOsC disseminate findings of Boundaries research into ‘How is touch communicated in the context of manual therapy?’ and commission further research</td>
<td>October</td>
<td>On track</td>
</tr>
<tr>
<td>8</td>
<td>Run a publicity campaign on the benefits of seeing a registered chiropractor and encourage practices to display the ‘I’m registered’ logo</td>
<td>December</td>
<td>Future task</td>
</tr>
</tbody>
</table>

## WE DEVELOP THE PROFESSION

*We will facilitate collaborative strategic work to support the profession in its development*

<table>
<thead>
<tr>
<th>Ref. No.</th>
<th>Business plan activity</th>
<th>Timescale</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Agree specific profession wide projects</td>
<td>July</td>
<td>Future task</td>
</tr>
<tr>
<td></td>
<td>Task Description</td>
<td>Due Date</td>
<td>Status</td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>----------</td>
</tr>
<tr>
<td>10</td>
<td>Complete specific profession wide projects</td>
<td>December</td>
<td>Future task</td>
</tr>
<tr>
<td>11</td>
<td>Co-ordinate the collation of a baseline of current work and plans to further develop research and governance</td>
<td>May</td>
<td>Future task</td>
</tr>
<tr>
<td>12</td>
<td>Agree a plan to further develop research and governance</td>
<td>November</td>
<td>Future task</td>
</tr>
<tr>
<td>13</td>
<td>Contribute to the collection and review of baseline data on workforce, education planning and diversity/inclusion</td>
<td>December</td>
<td>Future task</td>
</tr>
<tr>
<td>14</td>
<td>Produce and publish guidance and policy documents, as appropriate, that support chiropractors in best practice during 2019</td>
<td>Ongoing</td>
<td>Future task</td>
</tr>
</tbody>
</table>

**WE INVESTIGATE AND ACT**

*We will take right touch action on complaints, the misuse of title or where registration standards are not met*

<table>
<thead>
<tr>
<th></th>
<th>Task Description</th>
<th>Due Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Complete a full FtP review and implement changes to ensure we can be more 'right touch' within our current legal framework</td>
<td>August</td>
<td>Future task</td>
</tr>
<tr>
<td>16</td>
<td>Publish a revised approach to protecting the title ‘chiropractor’ and report on action we take</td>
<td>October</td>
<td>Future task</td>
</tr>
<tr>
<td>17</td>
<td>Review and publish our policies on judgements we make to decide if registration standards are met</td>
<td>August</td>
<td>On track</td>
</tr>
<tr>
<td>18</td>
<td>Regularly publish shared learning and intelligence from the work we, and other regulators, do during 2019</td>
<td>Ongoing</td>
<td>On track</td>
</tr>
</tbody>
</table>

**WE DELIVER VALUE**

*We will be a great place to work, work together and deliver effective /efficient services*

<table>
<thead>
<tr>
<th></th>
<th>Task Description</th>
<th>Due Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>Carry out a staff survey and work together to act on the results to embed our values and behaviours</td>
<td>March</td>
<td>On track</td>
</tr>
<tr>
<td>No.</td>
<td>Task Description</td>
<td>Due Date</td>
<td>Status</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>20</td>
<td>Complete a programme of work to refresh our HR approach including policies, pay and benefits and our staff handbook</td>
<td>December</td>
<td>On track</td>
</tr>
<tr>
<td>21</td>
<td>Establish and implement a new approach to personal development and review</td>
<td>March</td>
<td>On track</td>
</tr>
<tr>
<td>22</td>
<td>Deliver the first year of our three year financial sustainability plan</td>
<td>December</td>
<td>On track</td>
</tr>
<tr>
<td>23</td>
<td>Upgrade our registrations database so that it is fit for purpose and provides a better user experience</td>
<td>July</td>
<td>Possible delays</td>
</tr>
<tr>
<td>24</td>
<td>Revise our registration procedures so that the process is streamlined and effective</td>
<td>July</td>
<td>On track</td>
</tr>
<tr>
<td>25</td>
<td>Agree and launch a range of communication/engagement initiatives including our new newsletter for registrants and stakeholders during 2019</td>
<td>Ongoing</td>
<td>On track</td>
</tr>
<tr>
<td>26</td>
<td>Work with patient representatives to agree a patient involvement approach for the GCC’s work</td>
<td>September</td>
<td>Future task</td>
</tr>
<tr>
<td>27</td>
<td>Launch a new website</td>
<td>September</td>
<td>On track</td>
</tr>
</tbody>
</table>
1. Purpose

At its December 2019 meeting, Council approved a financial strategy to support the overall GCC strategy. This paper updates Council on various activities underway in support of that financial strategy.

2. Updates

The principal elements of the plan, with associated actions, are listed below:

a. Surplus levels:

The management accounts for the first few months of any financial year are notoriously difficult to rely on in determining the trend. A current surplus of £70.3k is shown (against an expected deficit budget of £94.9k) – a £165k variance. That said, it is premature to assert we have turned a financial corner.

Volumes in relation to Professional Conduct Committee (PCC) and Investigation Committee’s (IC) consideration of advertising cases are lower than budgeted to date this year (35% and 50%, respectively, of budgeted total panel days). We expect IC consideration of advertising to tail off in April, although PCC activity is expected to run at around two cases per month, as necessary.

We caution against drawing any conclusions from performance to date. Our current surplus is just under 15% against a target of 5%. As our investment in technology and process changes emerge later in the year this will come under pressure. Equally, it is a better picture than expected.

b. Investment portfolio performance:

During 2018, the investment portfolio (managed by Cazenove) had a negative net return for the year of 5.5%, in-line with performance for the rest of the market. A review meeting with Cazenove took place on 6 March 2019, and an improvement of 4.1% on valuations for performance to end February 2019 was reported.

The GCC’s financial strategy and changes to our portfolio parameters were discussed to reflect the strategy, and our investment policy proposals are covered elsewhere on the agenda.
c. System change – Click Travel:

On 1 March 2019 we introduced Click Travel - a self-serve on-line booking system for hotels and travel, for use by Members, staff and partners. The objective is to drive direct savings and administrative efficiency. So far:

- 24 bookings have been made – two flights, eight hotel bookings and 14 train tickets.
- All bookings have been compliant with the new policy.
- All bookings have been made online, so the GCC has not incurred administrative charges.
- Against the highest 'compliant' rate possible, savings of £784 have been made (classified by Click Travel as “Realised savings”).
- Against the lowest rate available for each booking, a further saving of over £2,800 could have been realised (classified by Click Travel as “Potential savings”). We are doing more work to explore this further – we suspect there is a balance to be struck between autonomy and driving down cost yet further.

In short, the system is in place and is working as desired, although more work is needed (once the system has been running for a few months) to see why bookers are not always taking the lowest possible rates and to better understand the analysis provided by Click Travel.

d. System change – Moorepay:

In January 2019, our payroll and HR system provided by Moorepay (our payroll bureau) was upgraded. Our rationale for doing so is to benefit from their integrated payroll and HR system, allowing for staff self-service, for example in recording sick leave and requesting leave and additional functionality. We are aiming for a phased launch from April 2019.

3. Action required

Council is asked to note the report.

4. Financial implications

There are no financial implications arising from this paper, other than those listed above.

5. Legal or Risk Implications

There are no legal or risk implications arising from this paper, other than those listed above.

6. Equality Implications

There are no equality implications arising from this paper.

7. Communications Implications

There are no communications implications arising from this paper.
1. Purpose
At its December 2018 meeting, Council approved a financial strategy to support its overall strategy. As part of the strategy, the proposal to update both the investment and the reserves policies were accepted. This cover paper sets out the key differences in the new policies.

2. Key changes in policies

a. Investment policy
The current GCC investment policy was approved in December 2015. The new financial strategy was approved at the December 2018 Council meeting, which incorporated an outline investment policy. The strategy was shared with the investment managers on 6th March 2019 and they have fed their thoughts in to the new policy.

Key changes in this policy are:
- Primary objective changed to ‘cover budgeted income from income and/or capital’ from ‘distribute 4% per annum (after fees), generated mainly from income (capital can also be used however)’.
- Reduce the long term objective to CPI + 3.0% (from CPI + 4%) to better align with the new primary objective.
- Reduce the attitude to risk to ‘medium to high’ from ‘high’.
- Reduce UK equities by 5% and introduce 5% cash to asset allocations to potentially increase liquidity and reduce overall risk.
- Update the short-term benchmarks to reflect the amended asset allocations.
- Change ‘Absolute Return’ to ‘Alternatives’ to include infrastructure and other assets.

b. Reserves policy
The current GCC reserves policy was approved in December 2015. An outline reserves policy was approved by Council at the December 2018 meeting as part of the financial strategy paper.

Key changes in this policy are:
- A risk based approach to setting the reserves has been used.
- Rather than an absolute general reserve figure of £2.9m being used, a proxy of six months’ expenditure will be used to set and monitor the level of general reserve.
- Excess reserves above the general reserve figure will be placed in a designated reserve and will be earmarked for particular use(s) by Council.
3. Action required

Council is asked to approve the:
- Investment policy
- Reserves policy

4. Financial implications

There are no financial implications arising from this paper, other than those listed above.

5. Legal or Risk Implications

There are no legal or risk implications arising from this paper, other than those listed above.

6. Equality Implications

There are no equality implications arising from this paper.

7. Communications Implications

There are no communications implications arising from this paper.
General Chiropractic Council Investment Policy

Introduction and Scope
1. The General Chiropractic Council’s investment portfolio is managed to help achieve the Council approved financial strategy.
2. This policy relates to investment assets held by the GCC and managed by an appointed investment management firm.
3. This policy has been prepared to provide a framework for the management of investment assets and it will be reviewed on an annual basis to ensure continuing appropriateness.

Objectives
4. The primary investment objective is to cover budgeted income from income and/or capital.
5. The secondary objective is to maintain the real value of the capital sum (after the distributions have been made).

Risk appetite
6. Council adopts a “medium to high” approach to risk overall and to minimise volatility wherever possible over the long term.
7. However, Council can tolerate short term capital volatility if necessary and accepts that a higher attitude to risk may be necessary to deliver on the returns required by the GCC.

Asset allocation and benchmarks
8. The long term benchmark for performance is CPI + 3%.
9. Short term comparators will be in line with the indices below:

<table>
<thead>
<tr>
<th>Asset classes</th>
<th>Benchmark</th>
<th>Ranges</th>
<th>Indices</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK equities</td>
<td>35%</td>
<td>25-45%</td>
<td>FTSE All-Share Index</td>
</tr>
<tr>
<td>Overseas equities</td>
<td>20%</td>
<td>10-30%</td>
<td>FTSE World Ex-UK</td>
</tr>
<tr>
<td>Fixed income</td>
<td>20%</td>
<td>10-30%</td>
<td>FTSE All-Stocks Index</td>
</tr>
<tr>
<td>Alternatives</td>
<td>10%</td>
<td>5-15%</td>
<td>7-day LIBID</td>
</tr>
<tr>
<td>Property</td>
<td>10%</td>
<td>5-15%</td>
<td>IPD Balanced PUT</td>
</tr>
<tr>
<td>Cash</td>
<td>5%</td>
<td>0-10%</td>
<td>7-day LIBID</td>
</tr>
</tbody>
</table>

10. Although we recognise that some funds may include an element of hedge funds within them, the Council does not want to invest directly in hedge funds.
Time horizon
11. Time horizons for investments and the size of the available assets will be confirmed as part of the budget setting process.

Liquidity needs
12. The Council would like to ensure a reasonable level of liquidity in the portfolio to ensure that any possible operating requirements can be met.
13. A high proportion of the portfolio will be held in investments with an active secondary or resale market.
14. Liquidity requirements for the following year will be defined annually as part of the budget setting process and, in the longer term, through the financial strategy.

Treasury management
15. It is the GCC’s policy to hold immediately available cash amounts equivalent to between 2-3 months’ operating expenditure.
16. Any excess cash will be invested in term deposits.
17. To reduce exposure to any one financial institute, no more than £250k will be held in any one institution, with the exception of the provider of the GCC’s operational banking needs.
18. Movements above £250k should be approved by the Chair of Council and Chair of Audit and Risk and notified to Council members.
19. Income earned by the investment portfolio is to be paid out to the GCC’s nominated bank account on a quarterly basis.

Credit risk
20. The GCC’s cash balances will be deposited with highly rated counterparties in client money bank accounts or in a diversified money market fund. Deposits will be spread between institutions and reports prepared on a regular basis showing the exposure by institution.
21. Bond exposure should be focused on investment grade issuers.

Currency risk
22. The base currency of the portfolio is sterling, but investments may be made in non-sterling assets.

Ethical investing
23. The GCC operates a negative screening approach to ethical investing (i.e. avoiding directly investing in unethical stocks that are against the GCC’s aims).
24. There should be no direct investment in armaments or tobacco production companies.
25. The GCC assets should also be invested in line with its aims and individual investments may be excluded if perceived to conflict with the GCC’s purpose.
Decision-makers
26. The GCC has nominated a list of authorised signatories, two of whom are required to sign instructions to the investment manager. This list is:
   - Chair of Council
   - Chair of Audit & Risk Committee
   - Chief Executive and Registrar
   - Finance Lead Officer

27. Drawdowns from the portfolio will be approved by Council through the annual budget process and may be authorised by any of the two authorised signatories.

28. Any drawdowns other than those approved through the annual budget process must be approved by both the Chair of Council and the Chair of Audit & Risk.

29. Any change to the nominated bank account that income or drawdowns are paid to must be approved by the Chair of Council and the Chair of Audit and Risk.

Reporting requirements
30. Quarterly valuation reports will be sent by the investment manager to nominated individuals at the GCC.

31. If available, online access to the portfolio will also be enabled for nominated individuals at the GCC.

32. The investment manager will meet with the lead finance officer twice a year to discuss the portfolio performance and the GCC’s forthcoming needs.

33. The investment manager will meet with Council once a year to discuss the portfolio performance.

Responsibility and remit of the investment manager
34. The GCC has appointed a professional investment management firm to manage the assets on a discretionary basis in line with this policy.

35. The investment manager will provide for the custody of assets.

36. The investment manager is required to provide reports as set out above and to provide for online access to the portfolio status at any time.

Responsibility of Council
37. The Council has the responsibility for monitoring the investment assets.

38. The Council will regularly review the portfolio, including an analysis of return, risk and asset allocation.

39. Performance will be monitored against agreed market benchmarks in the short term and the investment objectives over the long term.
General Chiropractic Council Reserves Policy

Introduction and Scope
1. The General Chiropractic Council’s (GCC) reserves are set and managed to help achieve the Council approved financial strategy.
2. This policy has been prepared to provide a framework for the management of reserves and it will be reviewed on an annual basis to ensure continuing appropriateness.

Policy
3. It is the GCC’s policy to maintain general reserves at around 6 months’ of budgeted operating expenditure.
4. Any excess funds will be placed in designated reserves and the Council will determine their use in line with the strategy.

Types of reserves and reasons for holding them
5. The GCC will operate four different reserves – General reserve, revaluation reserve, designated reserve and restricted reserve.
   i. General reserve – Council has no restrictions on the use of these funds for the carrying out its statutory duties. General Funds comprise all of the assets and liabilities of the Council except for those that are held in cash and form the assets of any restricted reserve (see below), or are designated by Council for a particular purpose.
   ii. Revaluation reserve – The investments are shown at market value in the balance sheet and the revaluation reserve identifies the difference between the book value and market value on the last day of the financial year.
   iii. Designated reserve – These are unrestricted funds that have been earmarked for a particular purpose by Council. The notes to the accounts will explain the purpose of any designated funds.
   iv. Restricted reserve – These are funds where the giver of the funds has placed restrictions on how the funds may be used. Currently, the GCC has one Restricted Reserve:
      • Department of Health Grant – The GCC received a grant from the Department of Health to enable the Council develop a risk proportionate system of continuous Fitness to Practice (Revalidation) for chiropractors
Level of reserves required

6. The level of required general reserve will be set using an approach based on risk.

7. The current calculation of the general reserve figure is as follows:

<table>
<thead>
<tr>
<th>Reserve</th>
<th>Reserve level</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration income</td>
<td>0.2m</td>
<td>Low risk, as income is highly stable</td>
</tr>
<tr>
<td>Investment income</td>
<td>-</td>
<td>Income reducing in significance and mandate can be changed to reduce risk around this area</td>
</tr>
<tr>
<td>Regulatory costs</td>
<td>0.3m</td>
<td>Annual PCC costs are £600k, so this would represent a 50% increase in cases dealt with</td>
</tr>
<tr>
<td>Income and expenditure</td>
<td>-</td>
<td>Losses and investments already in the plan</td>
</tr>
<tr>
<td>Contingency</td>
<td>1.0m</td>
<td>GCC could be wound up in 3-5 months, so estimate appears appropriate</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1.5m</strong></td>
<td></td>
</tr>
</tbody>
</table>

8. As such the general reserve is equivalent to approximately six-months of budgeted operating expenditure of each year. Accordingly a useful measure of performance indicating a reserve level is six months expenditure as an easily measurable proxy for the more detailed calculation above. However, the detail will be reviewed at least annually by Council.

Monitoring and reviewing the policy

9. This policy is to be reviewed annually.

10. Where changes occur that would affect the judgements made in the reserves policy, the policy should be reviewed and the adjusted reserves level should be brought to the attention of Council at its next meeting.

Reporting in the Annual Report and Accounts

11. The actual level of reserves at the year-end will be reported in the Annual Report and Accounts.

Agreed by Council March 2019
1. Purpose
The purpose of this paper is to provide an annual report on the GCC’s fitness to practise activity for 2018. The Council is asked to approve the publication of the report.

2. Background
The GCC publishes a report on its fitness to practise activity on an annual basis. This report is published to meet several objectives:

- Account to patients, the public, the profession, and other stakeholders on the Council’s protection duty
- To ensure that our processes are efficient and to improve if we can
- To extract learning and disseminate this to contribute to improvements of care provided by registered chiropractors

3. Action required
Council is asked to approve the publication of the report on the website.

4. Financial implications
There are no financial implications arising from this paper.

5. Legal or Risk Implications
There are no legal or risk implications arising from this paper.

6. Equality Implications
There are no equality implications arising from this paper.

7. Communications Implications
There are communications implications arising from this paper. There is an opportunity to communicate to the profession our findings, particularly in relation to the most common allegations that chiropractors were faced with and the nature of cases where chiropractors were found guilty of unacceptable professional conduct in 2018.
Dealing with concerns about Chiropractors in 2018:
Our annual report on Fitness to Practise
### 1. Duties and Objectives

The GCC:

- Sets the standards that it expects of chiropractors throughout their working lives
- Recognise chiropractic degree programmes that achieve our standards
- Administers a registration system for chiropractors to control their entry to, and continuation in the chiropractic profession in the UK
- Deals with chiropractors whose fitness to practise is called into question

This report covers our activity in dealing with the latter – our fitness to practise work.

We publish this report to meet several objectives:

- Account to patients, the public, the profession, and other stakeholders on the Council’s protection duty
- To ensure that our processes are efficient and to improve if we can
- To extract learning and disseminate this to contribute to improvements of care provided by registered chiropractors
2. About Fitness to Practise (FtP)

The Code

The Code represents the benchmark of conduct and practice against which chiropractors are measured.


The Code is arranged around eight principles that require chiropractors to:

- Put the health interests of patients first
- Act with honesty and integrity and maintain the highest standards of professional and personal conduct
- Provide a good standard of clinical care and practice
- Establish and maintain a clear professional relationship with patients
- Obtain informed consent for all aspects of patient care
- Communicate properly and effectively with patients, colleagues and other healthcare professionals
- Maintain, develop and work within professional knowledge and skills
- Maintain and protect patient information

Investigating complaints

The GCC must investigate any complaint made about a registrant. The types of complaint it can investigate are:

- Treatment, care or advice given by a chiropractor
- The professional or personal behaviour of a chiropractor
- Serious impairment of fitness to practise due to the physical or mental health of a chiropractor

What complaints are the GCC unable to investigate?

- The GCC can only investigate registered chiropractors
- The GCC regulates individual chiropractors and does not accept complaints against clinics
- The GCC cannot resolve matters that relate solely to payment
- The GCC has no power in relation to compensation whatsoever
The investigating process followed by the GCC fitness to practise team is as follows:

1. We receive a written complaint.
2. We carry out an investigation.
3. We invite the complainant to give us a statement of evidence.
   We may get more information from the complainant and other witnesses.
4. We send a copy of the complaint or statement to the chiropractor, who has 28 days to give observations.
   If relevant, we obtain chiropractic records.
5. We send the chiropractor’s observations to the complainant for comments.
   Any comments are sent to the chiropractor for additional observations.
6. The GCC Investigating Committee considers all the documentary evidence provided by both parties.
   The Committee may ask for more information before making a final decision.

Case to answer
The Committee draws up an allegation for referral to the GCC Professional Conduct Committee or Health Committee. We tell the chiropractor and the complainant the reason for the decision.

No case to answer
Case closed. We tell the chiropractor and the complainant the reason for the decision.
3. Summary performance

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of cases concluded by Investigating Committee</td>
<td>58</td>
<td>67</td>
</tr>
<tr>
<td>Number of cases concluded by Investigating Committee with the following outcome:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Case to Answer</td>
<td>47</td>
<td>51</td>
</tr>
<tr>
<td>Referral to Professional Conduct Committee</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Number of cases concluded by Professional Conduct Committee</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Number of registrants removed ('struck off') from the register</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Number of registrants suspended from the register</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Number of registrants receiving a conditions of practice order</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Number of registrants receiving an admonishment</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Time from receipt of initial complaint to the final Investigating Committee decision (in weeks):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td>Longest case</td>
<td>79</td>
<td>129</td>
</tr>
<tr>
<td>Shortest case</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Number of open cases (at the end of the year) which are older than:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>52 weeks</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>104 weeks</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>156 weeks</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Key points

- There were fewer complaints received about chiropractors in 2018 than in the previous year
- The most common concerns raised about a chiropractor's care related to inappropriate or excessive treatment and concerns about the type of treatment provided
- There was a slight reduction in the volume of cases referred from the IC to the PCC from 24% in 2017 to 19% in 2018. On average over the last five years, 30% of cases progress to PCC following the investigation stage.
- Cases were closed more quickly in 2018 than in previous years.
- At the end of 2018 only 7 cases that were awaiting determination by the PCC. This is a 22% decrease from 2017 and a 41% decrease from 2016 due to the lower rates of referral of the last few years.
4. Complaints received

We received fewer complaints about chiropractors’ fitness, reducing by 15% from 2017.

Those 61 complaints received in 2018, concerned the performance of 53 separate chiropractors.

Four registrants received two complaints against them and two registrants received three complaints against them in the year.

<table>
<thead>
<tr>
<th>Complaints received</th>
<th>2018</th>
<th>2017</th>
<th>2016</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>61</td>
<td>72²</td>
<td>43</td>
<td>56</td>
<td>65</td>
</tr>
</tbody>
</table>

Complaints received by month

On average we received 5 complaints per month in 2018 with a peak of 8 complaints received in December.

---

¹ This number may change as time progresses. Some ‘enquiries’ that we receive in a year may not be deemed a section 20 ‘complaint’ initially or at all. The date the ‘complaint’ is received may overlap with the date that we decide it has become a section 20 matter, for example, an enquiry could be received in 2018, but the decision that it should be considered as a section 20 ‘complaint’ may not occur until 2019.

² This figure was reported as 66 in the FtP report 2017. The final figure was 72 for the reasons set out in footnote 1.
Source of complaints

Most complaints are made by a patient or a relative of a patient. These account for 62% of all complaints in 2018.

There was a significant increase in complaints from anonymous complainants and an increase in the number of complaints received from other chiropractors in 2018.

<table>
<thead>
<tr>
<th>Source of complaints</th>
<th>Number of complaints</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Relative of</td>
<td>38</td>
<td>62%</td>
</tr>
<tr>
<td>Anonymous</td>
<td>11</td>
<td>18%</td>
</tr>
<tr>
<td>Other Chiropractor/Clinic where worked/Employee</td>
<td>7</td>
<td>11%</td>
</tr>
<tr>
<td>Member of public/private organisation</td>
<td>4</td>
<td>7%</td>
</tr>
<tr>
<td>Self Referral</td>
<td>1</td>
<td>2%</td>
</tr>
</tbody>
</table>

Nature of complaints

Understanding the nature and volumes of complaints contributes to the development of the profession. We want to support the profession by being transparent about complaints and where necessary provide guidance where there are common themes or trends.

Importantly, allegations raised are just that; allegations. Whether or not these are proven is not a consideration in this section of the report, but aids understanding of complaints made.

Our approach

Each complaint is reviewed by a GCC case worker, who completes an initial case report capturing the allegation and issues raised by the complainant. The case report records all allegations made, including multiple allegations by one complainant. As such the number of allegations is greater than the number of complaints received in the year (61).

Cases are assigned a category and broken down into type and, in some cases, subtype. For example, a complaint concerning injury from treatment is categorised as clinical care, the type would be substandard treatment and the subtype rough or aggressive treatment causing injury/pain.

<table>
<thead>
<tr>
<th>Category</th>
<th>Type</th>
<th>Subtype</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical care</td>
<td>e.g. substandard treatment/inadequate record keeping etc.</td>
<td>e.g. Rough/aggressive treatment causing injury/pain</td>
</tr>
</tbody>
</table>
Nature of complaint by category

Most complaints (80%) include multiple allegations made by a complainant against a chiropractor. On average each complaint contains more than three separate allegations. Often a single complaint contains allegations about both clinical care and communication/consent/professional relationships, thus crossing ‘category’. Of the 61 complaints received, there were 43 separate complaints that in some way alleged a failing relating to clinical care. In 24 of those, allegations were also made that related to a breakdown in the relationship between chiropractor and patient/complainant.

Base: 61 cases

<table>
<thead>
<tr>
<th>Nature of Complaint</th>
<th>Number of allegations raised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical care</td>
<td>106</td>
</tr>
<tr>
<td>Communication/Consent/Professional Relationships</td>
<td>71</td>
</tr>
<tr>
<td>Probity</td>
<td>17</td>
</tr>
<tr>
<td>Working with colleagues</td>
<td>8</td>
</tr>
<tr>
<td>Conviction/Criminality</td>
<td>6</td>
</tr>
<tr>
<td>Business/employment issues</td>
<td>1</td>
</tr>
<tr>
<td>Health</td>
<td>0</td>
</tr>
<tr>
<td>Teaching/Supervision</td>
<td>0</td>
</tr>
<tr>
<td>Compliance with GCC investigations</td>
<td>0</td>
</tr>
<tr>
<td>Unprofessional behaviour outside practice</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
</tr>
</tbody>
</table>

Clinical care by type and subtype

The most commonly occurring allegation relating to clinical care is the patient receiving substandard treatment.

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of allegations raised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substandard treatment</td>
<td>100</td>
</tr>
<tr>
<td>Inadequate record keeping</td>
<td>1</td>
</tr>
<tr>
<td>Poor hygiene practice</td>
<td>1</td>
</tr>
<tr>
<td>Breach of patient confidentiality</td>
<td>4</td>
</tr>
</tbody>
</table>
Substandard treatment

This covers a wide variety of concerns raised, for example the patient was injured and there was also no diagnosis.

<table>
<thead>
<tr>
<th>Subtype (Substandard treatment)</th>
<th>Number of allegations identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate/contraindicated/excessive treatment/lack of clinical justification</td>
<td>15</td>
</tr>
<tr>
<td>Concern about treatment techniques/approach/dissatisfied with treatment</td>
<td>14</td>
</tr>
<tr>
<td>Rough/aggressive treatment causing injury/pain</td>
<td>14</td>
</tr>
<tr>
<td>Failure to work within limits of knowledge, skills and competence</td>
<td>5</td>
</tr>
<tr>
<td>Misdiagnosis/No diagnosis</td>
<td>10</td>
</tr>
<tr>
<td>Inadequate assessment/case history</td>
<td>5</td>
</tr>
<tr>
<td>Lack of clinical justification for investigations/x-rays</td>
<td>5</td>
</tr>
<tr>
<td>Lack of further investigation/follow up/review</td>
<td>14</td>
</tr>
<tr>
<td>Failure to refer, when appropriate</td>
<td>10</td>
</tr>
<tr>
<td>Failure to examine/inadequate examination</td>
<td>2</td>
</tr>
<tr>
<td>Failure to cease treatment</td>
<td>4</td>
</tr>
<tr>
<td>Failure to adhere to x-ray guidelines</td>
<td>2</td>
</tr>
</tbody>
</table>

Communication/Consent/Professional Relationships by type and subtype

The second largest category of complaint is Communication/Consent/Professional Relationships.

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of allegations raised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>30</td>
</tr>
<tr>
<td>Failure to obtain informed consent from patient</td>
<td>9</td>
</tr>
<tr>
<td>Sexual boundaries</td>
<td>16</td>
</tr>
<tr>
<td>Failure to preserve patient's privacy and dignity/not providing chaperone</td>
<td>6</td>
</tr>
<tr>
<td>Intimidation of patient/pressure/undue influence to undergo treatment</td>
<td>10</td>
</tr>
</tbody>
</table>

Communication

Poor communication between patient and chiropractor consistently forms an element of or reason for a referral.
Subtype (Communication) | Number of allegations raised
--- | ---
Rudeness to patient/lack of respect or sympathy/empathy | 10
Inappropriate comments/language | 2
Failure to explain or agree diagnosis/treatment or treatment plan/results | 9
Failure to provide adequate information about complaints procedure | 6
Failure to explain refusal to treat | 1
Failure to respond to communication from complainant or comply with patient request | 2
Failure to explain fees adequately/mechanisms for payment | 0

The most commonly occurring complaint received related to the chiropractor being rude/showing lack of respect or sympathy/empathy. In all but one complaint of this subtype, it was in conjunction with a clinical care based failing.

A large number of complaints raised the subtype ‘failure to explain or agree diagnosis/treatment or treatment plan/results’.

**Sexual boundaries**

There was an increase in allegations made of a sexual nature in 2018. There were 11 separate complaints that alleged some kind of sexual behaviour by a chiropractor.

<table>
<thead>
<tr>
<th>Subtype (Sexual boundaries)</th>
<th>Number of allegations raised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate personal/sexual relationship with patient</td>
<td>4</td>
</tr>
<tr>
<td>Use of sexualised language/comments</td>
<td>5</td>
</tr>
<tr>
<td>Indecent/sexualised behaviour</td>
<td>4</td>
</tr>
<tr>
<td>Inappropriate contact with patient’s body/intimate areas</td>
<td>3</td>
</tr>
</tbody>
</table>

**Probity**

In this category, the largest number of allegations was where a chiropractor failed to fulfil the duty of candour of being open and honest with patients.
## Commonly occurring allegations in 2018

The most commonly occurring allegations in 2018 were:

1. Inappropriate or excessive treatment; concerns about the clinical justification of the treatment provided
2. Rough or aggressive treatment causing injury or pain to the patient
   = Concern about treatment techniques; the treatment plan followed by the chiropractor; general dissatisfaction with the treatment
   = A failure by the chiropractor to investigate, follow up or review the patient
3. Failure to fulfil duty of candour - to be open and honest with the patient when things go wrong
4. Shortfalls in diagnosing the patient – both misdiagnosis and failing to make a clear diagnosis
   = Failures by the chiropractor in referring the patient to other health and care professionals where it is appropriate to do so
   = The patient experiencing rudeness from the chiropractor which may include a lack of respect or sympathy/empathy
   = The patient experiencing undue pressure or influence to undergo treatment
5. Investigating Committee

The Investigating Committee (IC) investigates complaints made to the GCC about a chiropractor’s conduct, professional incompetence or health, to establish whether there is a 'case to answer'. If there is a case to answer, the IC will refer the complaint to the Professional Conduct Committee (PCC) or Health Committee (HC).

The IC meets in private. The Committee sits with a Legal Assessor to advise the Committee on points of law and procedure, but has no decision-making role.

In 2018, the IC determined 58 cases compared to 67 last year, however there was also a lower volume of complaints received in the period.

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases determined</td>
<td>58</td>
<td>67</td>
<td>43</td>
<td>41</td>
</tr>
<tr>
<td>Cases received</td>
<td>61</td>
<td>72</td>
<td>43</td>
<td>56</td>
</tr>
<tr>
<td>Received vs determined rate</td>
<td>95%</td>
<td>93%</td>
<td>100%</td>
<td>73%</td>
</tr>
</tbody>
</table>

**Cases determined by month**

On average the IC closed 5 complaints per month in 2018. This is the same as the average number of cases we received per month.
Decisions of the Investigating Committee

Of the 58 cases that were determined by the IC in 2018, 11 were referred on to the PCC (19%). This is the lowest rate of referral in the last five years.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No Case to Answer</td>
<td>47</td>
<td>51</td>
<td>28</td>
<td>25</td>
<td>54</td>
</tr>
<tr>
<td>Referred to PCC</td>
<td>11</td>
<td>16</td>
<td>15</td>
<td>16</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>67</td>
<td>43</td>
<td>41</td>
<td>81</td>
</tr>
</tbody>
</table>

Time taken for IC cases to be determined

We aim to conclude cases within 28 weeks from when they are received.

Of the 58 cases determined by the IC, 83% were determined within 9 months of the complaint being received. In the same period in 2017, 70% were determined with 9 months.

<table>
<thead>
<tr>
<th>IC Cases Determined</th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 4 months</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Within 6 months</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>Within 9 months</td>
<td>27</td>
<td>19</td>
</tr>
<tr>
<td>Over 9 months</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>67</td>
</tr>
</tbody>
</table>
6. Professional Conduct Committee

The Professional Conduct Committee (PCC) determines allegations about a chiropractor’s conduct or professional incompetence referred to it by the IC. Allegations that have been referred to the PCC are considered either at a public hearing or, on rare occasions, at a private meeting.

The PCC is formed of chiropractic and non-chiropractic (‘lay’) members. There must be at least three PCC members present at the meeting, and this must include one chiropractor and one lay member. The panel is chaired by a lay member. The PCC sits with a Legal Assessor, advising the Committee on points of law and procedure with no decision-making role.

If the PCC decides that the allegation against the chiropractor is not well founded, no further action will be taken. However, if the PCC decides that the allegation is well founded, it must impose a sanction.

Sanctions available to the PCC are

- Admonishment
- Conditions of Practice Order
- Suspension
- Removal from the Register

In 2018 there were 11 hearings where a determination was made by the PCC.

Three complaints referred from the IC were joined and heard at the same hearing. Therefore, 13 complaints were dealt with by the PCC.

Five chiropractors were found guilty of unacceptable professional conduct in 2018. The annex includes further details of these cases.

One chiropractor was removed from the register, two received conditions of practice orders and two received an admonishment.

In four cases the chiropractor was found not guilty of unacceptable professional conduct.

The GCC ‘offered no evidence’ in two cases. This occurs when there is insufficient evidence to support the allegations.

<table>
<thead>
<tr>
<th>PCC decision</th>
<th>2018</th>
<th>2017</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removal</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Suspension</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Conditions of Practice</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Admonishment</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>
CO-1903-8A Annex

**Review hearings**

Where a chiropractor has been either suspended or a conditions of practice order imposed at a previous hearing, a review hearing may be held to ensure the chiropractor is safe to return to the register.

There was one review hearing in 2018. The suspension order that was reviewed was extended for a further 9 months.

**PCC Caseload**

At the end of 2018 there were 7 cases that were still to be determined by the PCC. There were 9 PCC cases at the year end in 2017 (a 22% decrease) and 12 cases at the year end in 2016 (a 41% decrease over the two year period).

**Health Committee**

The Health Committee (HC) determines allegations of serious impairment of a chiropractor’s fitness to practise due to ill health.

The HC did not meet in 2018.

<table>
<thead>
<tr>
<th>No UPC</th>
<th>4</th>
<th>6</th>
<th>3</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCC offered no evidence</td>
<td>2</td>
<td>2</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>11</td>
<td>16</td>
<td>13</td>
<td>22</td>
</tr>
</tbody>
</table>
7. Advertising cases

At the beginning of 2018 the GCC began to process 306 complaints received from a single complainant about advertising standards. Recognising the importance of handling these complaints efficiently and effectively, a dedicated project team was established which is on track to complete the investigations by Spring 2019. The data on the ‘advertising cases’ are reported separately from our routine annual reporting.

Once all the advertising cases have been concluded, the learning from these cases will be shared by the GCC with the profession and stakeholders.

By the end of 2018, 140 cases had been to IC with 133 ‘no case to answer’ judgments and seven cases adjourned for further information.

| Number of advertising cases considered by Investigating Committee | 140 |
| Number of advertising cases concluded by Investigating Committee | 133 |
| Number of cases closed pre-Investigating Committee | 13 |
| Number of cases concluded by Investigating Committee | 133 |
| with the following outcome: | |
| No Case to Answer | |
| Referral to Professional Conduct Committee | 0 |
| Adjourned | 7 |
| Number of Investigating Committee days | 29 |
| Remaining cases at year end | 160 |
8. Interim Suspension hearings

Investigating Committee

If a complaint received raises an immediate concern for the protection of the public, the IC will hold an ‘interim suspension’ hearing to consider whether it should suspend the registration of the chiropractor being investigated.

If the IC decides that it needs to suspend the registrant to protect the public, the order cannot last longer than two months and will be in place while the complaint is investigated. If granted, the Interim Suspension Order is effective immediately. The Committee has no power to revoke an order once it has been made.

There were three IC interim suspension hearings held in 2018. None of these hearings resulted in a suspension.

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>%</th>
<th>2017</th>
<th>%</th>
<th>2016</th>
<th>%</th>
<th>2015</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not interim suspended</td>
<td>3</td>
<td>100%</td>
<td>6</td>
<td>86%</td>
<td>10</td>
<td>77%</td>
<td>2</td>
<td>67%</td>
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<tr>
<td>Suspended</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>14%</td>
<td>3</td>
<td>23%</td>
<td>1</td>
<td>33%</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>7</td>
<td>13</td>
<td>13%</td>
<td>3</td>
<td>3%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Professional Conduct Committee

If the PCC decides that a complaint that has been referred to it by the IC is so serious that the public might need immediate protection, it will hold an interim suspension hearing. If the PCC decides that it needs to impose an Interim Suspension Order to protect the public, the Order is effective immediately, and it lasts until the end of the PCC process.

There were no PCC interim suspension hearings held in 2018.
9. Section 32 complaints

Under Section 32 of the Chiropractors Act 1994, a person who (whether expressly or by implication) describes themselves as a chiropractor, chiropractic practitioner, chiropractitioner, chiropractic physician, or any other kind of chiropractor, is guilty of an offence unless he/she is a registered chiropractor.

Over the course of a year, we receive a number of complaints that relate to individuals that describe themselves as above.

At the end of 2018, there was a backlog of these types of complaints. External resources have been engaged to assist with this work.

Open cases at year end

There were 95 separate referrals that were live at the end of 2018, however cases where the same individual is complained about are dealt with at the same time. Therefore, 75 referrals are being dealt with.

| Number of open s32 referrals | 95 |
| Number of individuals that each referral relates to | 75 |

Status of cases

| Cases reviewed | 75 |

Following review, action taken can include sending an initial letter that advises the individual to make changes to their website/publications. Other options include sending a 'cease and desist' letter, instructing inquiry agents to obtain more information or recommending that the case is closed. Where letters have been sent, we check that appropriate action has been taken by those complained about as a result.

Actions taken

| Advisory letters sent | 3 |
| Cease and Desist letters sent | 43 |
| Inquiry agent instructed | 16 |
| Recommended for case closure | 29 |
## Annex

**Summary of Professional Conduct Committee cases where the Chiropractor was found guilty of Unacceptable Professional Conduct**

<table>
<thead>
<tr>
<th>Name and registration number</th>
<th>Source of complaint</th>
<th>Summary of allegation(s) found proved</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>WOODS, Paul 01277</td>
<td>Conviction</td>
<td>Conviction relating to three offences of making indecent photographs or pseudo-photographs of a child</td>
<td>Removed from the register</td>
</tr>
<tr>
<td>PHELPS, Richard 03143</td>
<td>Patient</td>
<td>Failure to adequately re-assess a patient to formulate an appropriate diagnosis and/or treatment plan and treatment causing an adverse reaction and failure to adequately respond to this</td>
<td>Conditions of Practice order of 18 months</td>
</tr>
<tr>
<td>MATHEW, Benjamin 02665</td>
<td>Patient</td>
<td>Various issues including misleading and inappropriate comments/claims, patient confidentiality, consent issues, x-ray justification, poor record keeping</td>
<td>Conditions of Practice order of 12 months</td>
</tr>
<tr>
<td>AKINDELE, Kolawole 01047</td>
<td>Conviction</td>
<td>Conviction relating to twenty five offences relating to the Housing Act 2004 and one offence contrary to section 16(2) of the Local Government (Miscellaneous Provisions) Act 1976</td>
<td>Admonishment</td>
</tr>
<tr>
<td>COLLINS, Sheena 02061</td>
<td>Conviction</td>
<td>Conviction relating to driving under the influence of alcohol</td>
<td>Admonishment</td>
</tr>
</tbody>
</table>
GCC v Paul Stephen Woods

Registration number: 01277

Date of decision: 26 February 2018

Sanction: Removed from the Register

**Summary of conviction**

Mr Woods was convicted of a criminal offence in that:

- On 28 July 2017, Mr Woods pleaded guilty to three offences of making indecent photographs or pseudo-photographs of a child. On 1 September 2017, Mr Woods was sentenced to 4 months suspended for 12 months, with a Rehabilitation Activity Requirement on each count to run concurrently, a Sexual Harm Prevention Order for 7 years, costs of £300 and placed on the Sex Offenders Register for 7 years.
Summary of allegations found proved and consequently amounting to a finding of unacceptable professional conduct

On 21 and 22 July 2016, Mr Phelps provided chiropractic treatment to Patient A, who had been a patient of the Clinic since 13 May 2016.

On 21 July 2016 Mr Phelps failed to adequately re-assess Patient A’s condition to formulate an appropriate diagnosis and/or treatment plan in that:

- Her symptoms had changed significantly since her last presentation; and/or
- Her symptoms were suggestive of a new neurological condition.

On 22 July 2016 Mr Phelps adjusted or attempted to adjust Patient A’s spine following which she:

- Suffered an adverse reaction; and/or
- Was unable to sit or stand up; and/or
- Complained of increased pain and neurological lower limb symptoms.

In doing so Mr Phelps failed to adequately respond to these reactions in that he:

- did not carry out an adequate/or any neurological or orthopaedic assessment; and/or
- did not call for emergency medical assistance sufficiently promptly or at all; and/or
- suggested to Patient A’s mother that an ambulance was not required.

In addition, Mr Phelps further manipulated and/or attempted to manipulate Patient A’s lumbar spine. This was inappropriate in that he had not carried out an adequate re-evaluation of Patient A’s condition.
GCC v Benjamin Gartside Mathew

Registration number: 02665

Date of decision: 21 September 2018

Sanction: Conditions of Practice order for a period of 12 months

Summary of allegations found proved and consequently amounting to a finding of unacceptable professional conduct

The Committee found a significant number of Particulars proved in this case on matters including:

- the making of misleading comments at a talk, with the potential to deter parents from having their children vaccinated against measles and women from participating in mammographic screening to detect breast cancer; through the use of “Health Check Pass” cards
- the making of inappropriate claims about the efficacy of chiropractic or its potential for the treating of certain conditions, where he either knew, or ought to have known, it was inappropriate to do so;
- a gross breach of patient confidentiality;
- an oversight which led to a patient not being properly informed about her care options which impacted upon the validity of her consent;
- failures to comply with the statutory requirements of IRMER in the taking of unjustified x-rays, thereby exposing patients to the risk of unnecessary and harmful radiation;
- poor record keeping in a variety of areas including the recording of diagnosis and the reporting on radiographs.
GCC v Kolawole Akindele

Registration number: 01047

Date of decision: 30 August 2018

Sanction: Admonishment

Summary of conviction

On 20 November 2015 Mr Akindele was convicted of twenty five offences relating to the Housing Act 2004 and one offence contrary to section 16(2) of the Local Government (Miscellaneous Provisions) Act 1976.
**Summary of conviction**

On 15 June 2017 Ms Collins was convicted at the Cheshire Magistrates' Court of a criminal offence, namely that on 28 May 2017 she drove a motor vehicle on a road after consuming so much alcohol that the proportion of it in her breath, namely 115, exceeded the prescribed limit, contrary to Section 5(1)(a) of the Road Traffic Act 1988 and Schedule 2 to the Road Traffic Offenders Act 1988.
1. Introduction

The PCC continued with its statutory duties in 2018 as well as undertaking other activities and work throughout the year.

Chair of PCC

In January 2018, I was appointed overall Chair of the PCC. The role provides an important link between the GCC and the PCC. Whilst the Committee is independent in its judicial activity, it is right that Committee members understand the operational priorities of the GCC and are aware of the environment in which it operates. The Chair’s role contributes to this. At the same time, it is vital that communication between the Committee and the GCC is formalised where appropriate and that the Committee is able to speak with one voice on matters of mutual interest. An example of this is a recent request for information from the PSA. Along with the Head of Fitness to Practise and the Chair of the Investigating Committee, I provided the Committee’s response to the questionnaire. During the year, I have liaised regularly with the staff team and have maintained dialogue with GCC managers. I met with Rosalyn Hales and Tricia McGregor, although I have not yet had the opportunity of meeting with Nick Jones. I hope to do so at the Council meeting.

Hearings

The Committee concluded 11 substantive hearings in 2018. Three complaints referred from the Investigating Committee were joined and heard at the same hearing (listed for 20 days). Therefore, 13 complaints were dealt with by the PCC. Two of the cases that were concluded in the year had been previously adjourned in 2017.

There were 2 cases where chiropractors were found guilty of UPC. In a further 3 cases, the registrant had been convicted of a criminal offence. The new Guidance on Sanctions, published in April 2018, was used when considering the appropriate sanction for each case where the allegation was held to be well-founded.

A key achievement of the year was concluding the complex and consolidated ‘3 in 1’ hearing within the predicted 20 days for which it was listed, with only a few hours to spare. Ensuring that the case ran effectively was paramount due to the large number of witnesses and complexity. It is testament to all involved that this case was dealt with appropriately and concluded without any setbacks. The Committee imposed a conditions of practice order and arrangements have been put in place to monitor the order. A review hearing will be listed, most likely in August/September 2019.
There were a number of hearings where video conferencing was utilised for both panel members and witnesses. This caused no detrimental effects on the hearings, which progressed and concluded as if the person concerned had been in attendance in the conventional way.

**Hearing days and reduction in case load**

At the end of 2018, there was the least amount of cases in the pipeline at the year-end for many years (a reduction of 22% from the start of 2018, a reduction of 41% from 2017).

There were 71 listed hearing days in 2018. In 2017, the GCC listed 145 hearing days. In 2018, 27% of the listed hearing days were not used, due to cases either concluding early, going part heard or not continuing for other reasons. This improves on both 2017 (33%) and 2016 (28%). Most other regulators annually average at 30%.

**Training**

PCC training took place in March 2018 with 14 Committee members (4 Chairs, 6 lay and 4 chiropractors) attending. Unconscious bias training was tailored specifically to the PCC. The Committee discussed issues such as remaining impartial despite a recurrence of expert witnesses and cases being presented by the same counsel. Feedback after the training event, and subsequent informal discussions with Committee colleagues, confirmed that the training was well-received and properly focused on an issue which is very pertinent to the PCC.

Training also included a case law update, specifically focusing on the new test for dishonesty [*Ivey v Genting Casinos UK*], which has much relevance to the PCC’s work. A review of recent hearings where it has been necessary for the PCC to consider the new test suggests that it has been understood and is being correctly applied.

**Co-option process**

A co-option process for new lay members of the PCC took place and was agreed by Council in December 2018. Current lay members of the PCC were asked to identify and recommend potential candidates with whom they may have worked at another healthcare regulator and whom they believed would be a good addition to our pool. Nominated candidates were then sent details of how to apply, which required submitting a CV and short supporting statement setting out why they would be suitable for appointment. The applications were then assessed by myself and the Director of Education, Registration and Standards. We considered that the applicants were well-established professionals who would bring an appropriate mix of skills and background to the role. We were pleased to see that Council approved our decision to offer each of the four candidates a period of co-option. One new colleague has already sat on a PCC case.

**Issues/difficulties**

In 2018, there were a number of cases where members dropped out at short notice, for various reasons such as health or conflicting commitments. In many of these cases, the hearings still took place thanks to the goodwill of other PCC members who changed their arrangements at short notice in order to sit, avoiding the need to postpone the case. There was one case where a postponement was unavoidable due to the Chair being held over in criminal court from the week prior to the hearing.
There were difficulties in listing certain cases due to the registrant having more than one set of allegations brought against them. Where interim suspension hearings were needed, this can create listing difficulties because of the need to find Committee members who have had no previous dealings with the registrant. This was a factor which drove the co-option process. We have now built in added flexibility with lay members, and plan to do so for registrant members in the next few months, subject to the agreement of Council.

**Upcoming work**

A recruitment drive to extend the registrant pool of the Committee is being planned for 2019. It is expected that this will improve the diversity of our pool as well as giving the GCC greater flexibility with listings.

A process will be undertaken later in the year where current lay members will be given the opportunity to apply to become ‘lay chairs’. The process will coincide with current legally qualified chairs coming to the end of their contracts. Existing legally qualified chairs will be invited to apply to become lay chairs, should they so wish, but will be the subject of the same selection criteria and, if appointed, will be paid at the lay chair rate.

All panel members will take part in an appraisal process in the summer.

2. **Financial implications**

There are no financial implications arising from this paper.

3. **Legal Implications**

There are no legal implications arising from this paper.

4. **Risk Implications**

There are no risk implications arising from this paper.

5. **Equality Implications**

There are no equality implications arising from this paper.

6. **Communications Implications**

There are no communications implications arising from this paper.
1. Purpose

The purpose of this paper is to present the annual registrations report covering activity during 2018, annexed.

2. Main points of the report

The following points are brought to council’s attention:

I. The register as a whole has increased by only 0.6%, representing the third consecutive annual reduction in growth and means that the Register has increased by only 19 registrants at the end of 2018. Further information can be found on page 4 of the report.

II. The number of UK graduates applying for registration dropped from 170 in 2017 to 126 in 2018. Further information can be found on page 7.

III. Fewer candidates took the Test of Competence. 19 candidates made a total of 21 attempts at the test during the year: 13 fewer attempts than in 2017. Further information can be found on page 10 of the report; and

IV. We have included statistics relating to all collected data on protected characteristics relating to the Equality Act, both for new registrants and the register as a whole and which can be found from page 28 onwards.

Council may wish to further discuss the static, and diminishing, growth figures and other trends as appropriate.

3. Action required

Council is asked to note the report.

4. Financial implications

There are no financial implications arising from this paper.

5. Legal or Risk Implications

There are no legal or risk implications arising from this paper.

6. Equality Implications

There are no equality implications arising from this paper.

7. Communications Implications

We will wish to publish the report, and highlight in the GCC monthly newsletter.
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</tr>
</thead>
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<td>6</td>
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<td><strong>Routes to registration</strong></td>
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<td>8</td>
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<td>12</td>
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<tr>
<td>Retentions on the register</td>
<td>22</td>
</tr>
<tr>
<td>Removals from the register</td>
<td>24</td>
</tr>
<tr>
<td>Diversity of registrants</td>
<td>28</td>
</tr>
<tr>
<td>Communications</td>
<td>34</td>
</tr>
</tbody>
</table>
Report on the 2018 registration year

This report provides an overview of the General Chiropractic Council (GCC) registration activity between from 1 January to 31 December 2018.

The register

The register of Chiropractors opened in 1999, and since then over 4,700 chiropractors have registered. At 31 December 2018, there were 3,239 chiropractors on the GCC register: with 3,006 having paid the practising fee and 233 the non-practising fee.

Figure 1 – total number of registrants at the end of each year since 2007

What this tells us

There has been a steady increase in the total number of registrants since 2007, with 799 more at the end of 2018 than 2007 and therefore on average the register is growing at an average of 80 registrants each year.

Figure 2 – accumulative percentage increase in registrant numbers since 31 December 2007
What this tells us

The accumulative percentage increase on the 31 December 2007 figure of 2,440 is 32.7%. As chiropractic is a relatively small profession in the UK there is further scope for growth and we should expect increases in the future size of the profession, although these numbers are likely to be small given the numbers of UK graduates and applicants from overseas. Further consideration is given to potential future trends on page 24 of this report.

Figure 3 – percentage year on year growth in registrant numbers since 2007

What this tells us

While the population of the register increases year on year, the percentage growth has only added small increases over the past three years. In 2018 there was a further reduction in the growth of the register, dropping to 0.6%, and representing an increase of only 19 registrants in total. This can be partly explained by the continued reduction in the number of registrants paying the non-practising rate, which the GCC has encouraged as it considers non-practising a rate that it is only appropriate to pay for a few years. In addition there have been fewer graduates from UK chiropractic educational institutions in total, which is expanded upon on page 8, added to which is the uncertainty caused by EU exit.

Figure 4 – percentage increase in practising registrants
What this tells us
The increase of practising registrants slowed to 1.7% in 2018, the third consecutive reduction in the rate of growth from a high of 3.7% in 2015. This is largely due to fewer UK graduates coming through over the next few years. When looking at this figure it is important to also remember that:

- the register as a whole increased by only 0.6% in 2018, 19 registrants in total
- the number paying the non-practising rate fell to 233, but those practising has increased by 50
- the GCC has encouraged registrants to allow their registration to lapse rather than paying the reduced fee, unless they intend returning to practise in the short-term; and
- any increase in growth is more dependent on an increase in UK chiropractic programmes than applicants from overseas

Figure 5 – number of registrants paying the non-practising fee since 2012

What this tells us
There has been a marked decrease in the number of registrants paying the non-practising rate since 2015, with 30 fewer in 2018 than 2017. This is the lowest number since we began collecting data in 2012 and is an achievement given the restrictions placed on the GCC by the legislative framework. This is important to note as it is practising registrants in the UK who represent the greatest risk to public protection. Further data is given on page 24 with the reasons registrants gave for paying the lower fee. This has been identified by the council as something for further investigation during 2019 both to reduce the figure further but also to ensure the non-practising rate is not being abused.
New Registrants during 2018
An overview of 2018 new registrants

148 chiropractors joined the register in 2018, 47 fewer than in 2017 when 195 were registered. The number of new registrants by month was as follows:

Table 1 – number of new registrants by month since 2013

<table>
<thead>
<tr>
<th>Year</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
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<td>2018</td>
<td>10</td>
<td>11</td>
<td>9</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>25</td>
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<td>2017</td>
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<td>2015</td>
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<td>32</td>
<td>39</td>
<td>19</td>
<td>6</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>

What this tells us
The highlighted figures above illustrate clearly where the highest number of applications are received year on year. It is notable that in July and September 2018 the number of new registrants was significantly lower than in the previous year.

The chart below shows where peaks in initial registration applications occur during the year.

Figure 6 – number of new registrants by month since 2013

What this tells us
The majority of applications are received between July and September, with a further small flurry between November and January. This follows from students graduating from the UK institutions offering accredited chiropractic training courses and makes up the vast majority of registration applications.

The 2018 figure show a spike in August as with previous years, but those months either side had fewer applications. As we are expecting to see relatively similar numbers of applications
for the next few years the figures indicate that August is the month we are most likely to see the largest portion of applications and which will help in allocation of resources.

Table 2 - 2018 new registrants by registration route

<table>
<thead>
<tr>
<th>Registration route</th>
<th>Total new registrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Route 1 – UK accredited course</td>
<td>126</td>
</tr>
<tr>
<td>Route 2 – Foreign qualified</td>
<td>17</td>
</tr>
<tr>
<td>Route 3 – EU General Directive</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>148</strong></td>
</tr>
</tbody>
</table>

What this tells us

In total 126 UK graduates registered in 2018 making up the largest proportion of new registrants, although significantly lower than the 170 who registered in 2017. In addition, 17 applicants registered on the basis of holding a foreign chiropractic qualification after having passed the Test of Competence. The remaining 5 registrants with EU community rights and applied based on a previous period of practise elsewhere in the European Economic Area (EEA). The numbers applying with overseas qualifications remains relatively static, partly due to the upper constraints on the places available on the Test of Competence and the small numbers applying through the EU General Directive.

Given that the UK’s exit from the EU is due to be completed during 2019, we may see the effects of this trickling through the registration figures during that year, although since the majority of applications are from accredited UK courses we expect this will have a limited impact.
Routes to GCC registration
The route an applicant takes to registration depends primarily on their chiropractic qualification. Nationality is also taken into consideration where European law applies.

Route 1 – recognised qualification from an accredited course (UK)
Applicants must hold a chiropractic qualification recognised for the purposes of registration by the GCC. The GCC has accredited courses within the UK and therefore only graduates from those courses may apply through this route, (Anglo-European College of Chiropractic, McTimoney College of Chiropractic and the University of South Wales).

Route 2 – unrecognised overseas chiropractic qualification (Test of Competence)
Applicants must hold a chiropractic qualification from outside the UK that meets the requirements of our rules and also demonstrate they meet our educational standards by passing the Test of Competence.

Route 3 – EU General Directive (establishment)
Applicants must possess EU community rights and have practised, or be registered to practise, in another EEA member state.

Route 4 – EU General Directive (temporary and occasional)
Applicants must possess EU community rights, have practised, or be registered to practise, in another EEA member state and intend practising in the UK only on a temporary and occasional basis.

Applicants holding UK recognised qualifications (route 1)
The GCC currently accredits courses from four UK educational institutions. Only graduates from accredited colleges are eligible to apply for registration on the basis that they hold a qualification recognised for the purposes of registration. In 2018 the GCC accredited a master’s degree programme from the London South Bank University for the first time. The first cohort will not graduate until 2022 and even then that cohort is expected to be relatively small.

The GCC accreditation standards are set out in the GCC Education Standards, which reflect The Code: Standards of conduct, performance and ethics for chiropractors (2016). The accreditation process is the procedure the GCC employs to assure outcomes of accredited courses and includes reviews to ensure compliance.

The following table gives the numbers of 2018 graduates from accredited courses registered before 1 March 2018.
Table 3 – new registrants by institution

<table>
<thead>
<tr>
<th>Educational institution</th>
<th>Month course completed</th>
<th>Number of graduates</th>
<th>Number registered</th>
<th>% of those graduates registered during 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>McTimoney College of Chiropractic (MCC)</td>
<td>October/ December 2017(^1)</td>
<td>30</td>
<td>28</td>
<td>93%</td>
</tr>
<tr>
<td>Anglo-European College of Chiropractic (AECC)</td>
<td>June/ July 2018</td>
<td>91</td>
<td>46</td>
<td>51%</td>
</tr>
<tr>
<td>University of South Wales</td>
<td>June/ July 2018</td>
<td>57</td>
<td>45</td>
<td>79%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td>178</td>
<td>119</td>
<td>67%</td>
</tr>
</tbody>
</table>

What this tells us

As has been seen in previous years a higher percentage of graduates from MCC registered than for the other two colleges as they have a smaller number of overseas students who then return to their home country after completing the course. The overall figure of registering graduates for 2018 is similar to that seen in previous years.

Table 4 – percentage of graduates from educational institutions registering since 2013

<table>
<thead>
<tr>
<th>Educational institution</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>McTimoney College of Chiropractic (MCC)</td>
<td>86%</td>
<td>86%</td>
<td>86%</td>
<td>91%</td>
<td>88%</td>
<td>93%</td>
</tr>
<tr>
<td>Anglo-European College of Chiropractic (AECC)</td>
<td>43%</td>
<td>53%</td>
<td>40%</td>
<td>36%</td>
<td>63%</td>
<td>51%</td>
</tr>
<tr>
<td>University of South Wales</td>
<td>92%</td>
<td>75%</td>
<td>66%</td>
<td>68%</td>
<td>68%</td>
<td>79%</td>
</tr>
</tbody>
</table>

What this tells us

There was a drop in the percentage of AECC graduates applying for registration during 2018, although the figure was still relatively higher than either 2013 or 2016. AECC has a larger proportion of students from overseas who often return home once they have completed the programme. This may impact on future registrations as the UK leaves the EU and also on future student numbers. Those EU graduates returning to their home state to practise are normally expected to register with the GCC if chiropractic is regulated in that state in order to apply via the EU General Directive (see page 19) and who often register only as non-practising for a few months until the end of the year.

More graduates from the University of South Wales registered during 2018 than since 2014. However, since there where fewer graduates this has not led to a large increase in registrants as the percentage registering has increased.

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\(^1\) Graduates from the McTimoney College of Chiropractic 2017 cohorts are included as they first register during the 2018 registration year.
Applicants holding relevant foreign chiropractic qualifications (route 2)

Applicants with chiropractic qualifications achieved from outside the UK must pass the Test of Competence before being eligible to apply for registration. The Test of Competence is designed to ensure applicants without a recognised qualification meet the same standards as those who do.

Table 5 – new foreign qualified applicants registered during 2018 (by educational institution)

<table>
<thead>
<tr>
<th>Educational institution</th>
<th>Country</th>
<th>Number of registrants</th>
<th>Year of graduation (total graduates in brackets)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian Memorial Chiropractic College (CMCC)</td>
<td>Canada</td>
<td>1</td>
<td>1982</td>
</tr>
<tr>
<td>Logan University</td>
<td>US</td>
<td>1</td>
<td>2017</td>
</tr>
<tr>
<td>Murdoch University</td>
<td>Australia</td>
<td>2</td>
<td>2010 2018</td>
</tr>
<tr>
<td>Macquarie University</td>
<td>Australia</td>
<td>1</td>
<td>2007</td>
</tr>
<tr>
<td>New Zealand College of Chiropractic (NZCC)</td>
<td>New Zealand</td>
<td>2</td>
<td>2013 2015</td>
</tr>
<tr>
<td>Palmer College</td>
<td>USA</td>
<td>3</td>
<td>2016 ×3</td>
</tr>
<tr>
<td>Palmer College – West</td>
<td>USA</td>
<td>1</td>
<td>1991</td>
</tr>
<tr>
<td>Parker College</td>
<td>USA</td>
<td>1</td>
<td>2011</td>
</tr>
<tr>
<td>Royal Melbourne Institute of Technology (RMIT)</td>
<td>Australia</td>
<td>1</td>
<td>2017</td>
</tr>
<tr>
<td>University of Johannesburg</td>
<td>South Africa</td>
<td>3</td>
<td>2010 ×2 2018</td>
</tr>
<tr>
<td>University of Western States</td>
<td>USA</td>
<td>1</td>
<td>2017</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td><strong>17</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

What this tells us

Candidates continue to apply from a wide range of colleges. 2018 saw fewer candidates from Macquarie University, but more from Palmer College. In addition no graduates from Durban Institute of Technology applied.

Eight candidates applied within five years of graduating, while two had graduated over twenty years before applying.
Table 6 – Test candidates by institution since 2013

<table>
<thead>
<tr>
<th>Chiropractic College</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian Memorial College of Chiropractic</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Cleveland College of Chiropractic</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Durban Institute of Technology</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Institut Franco-Européen de Chiropratique</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Life University</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Life – West University</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Logan University</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Macquarie University</td>
<td>7</td>
<td>9</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Murdoch University</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>National University of Health Sciences</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>New York College of Chiropractic</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>New Zealand College of Chiropractic</td>
<td>1</td>
<td>0</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Palmer College of Chiropractic</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Palmer – West College of Chiropractic</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Parker College of Chiropractic</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Université du Québec à Trois-Rivières</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Royal Melbourne Institute of Technology</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Southern California University of Health Sciences</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>University of Johannesburg</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>University of Western States</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

What this tells us

Applications were received from the same colleges in South Africa, Australia and New Zealand as previously, which is largely due to the small number of chiropractic colleges outside the US. In addition a small number of candidates were received from colleges in the US with three from Palmer College of Chiropractic, although since there are significantly more colleges offering chiropractic programmes these vary year on year.

Also of note is that only one candidate graduated from Macquarie University, where as in the past we have received multiple applications from Macquarie University graduates.

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2 Colleges are highlighted to denote 2018 figures.
Test of Competence

The Test of Competence is made up of the following components:

1. Candidates send us:
   - a completed Evidence of Practice Questionnaire, demonstrating how they meet the standards of The Code: Standards of Performance, Conduct and Ethics for Chiropractors, as well as their understanding of chiropractic in the UK.
   - anonymised patient records
   - a copy of their CV/ Resumé; and
   - evidence of the content of the chiropractic degree course they followed.

2. Candidate maps the chiropractic course against GCC Education Standards

3. The candidate attends an interview. An assessment panel meets to review each candidate's documents before the test interview, to determine whether any part of The Code has not been fully demonstrated. If so, questions are tailored by the panel to ensure those aspects are covered at interview.

While it is possible to submit an application for the Test of Competence at any time, the GCC runs test interviews on four dates each year, normally in January, March, June and September. We try to ensure similar dates are set each year for consistency and to aid candidates who may need to make travel and/or relocation arrangements.

Test outcomes

There are three possible test outcomes, either where:

1. The candidate satisfies the assessment panel they have provided sufficient evidence in all areas.

2. Where there is insufficient evidence in a few/uncritical areas. In which case additional specific information is required by the panel to cover these areas within a six month period, before a final decision is made on the application. Following submission of this additional information, the panel chair will assess the information, after which the applicant may go on to pass the test.

3. Where there is insufficient evidence in the majority of areas/ or where there are clear concerns above patient safety the candidate will fail and must complete the entire test again.

2018 Test of Competence results

The Test of Competence has been running in its current format since 2015.

In 2018 19 candidates took the test and 21 attempts were made; two candidates took the test twice. Of those 19 candidates 10 have since registered.

A total of 7 candidates were asked to provide further evidence in a total of 15 subjects and so the average number of subjects per candidate was two. This is slightly lower than 2017 when on average each request for additional information covered two and a half subjects.
Report on the 2018 GCC registration year

Table 7 - number of individual test candidates since 2013

<table>
<thead>
<tr>
<th>Year</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of candidates</td>
<td>17</td>
<td>20</td>
<td>17</td>
<td>32</td>
<td>33</td>
<td>17</td>
</tr>
</tbody>
</table>

What this tells us
The number of candidates taking the test in 2018 fell back to pre-2016 figures. It is too early to determine whether the UK vote to exit the EU has had an impact on numbers, in which case we may see a future increase, or whether the two years with in excess of 30 candidates taking the test were unusual and that the norm is around 17 candidates per year.

Table 8 – 2018 initial results by individual test

<table>
<thead>
<tr>
<th>Initial test results</th>
<th>Jan-18</th>
<th>Mar-18</th>
<th>Jun-18</th>
<th>Sept -18</th>
<th>Total</th>
<th>Total %age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pass</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>7</td>
<td>33%</td>
</tr>
<tr>
<td>Fail</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>7</td>
<td>33%</td>
</tr>
<tr>
<td>Insufficient Evidence</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>7</td>
<td>33%</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>

Figure 7 - comparison of initial test results by percentage since 2015

Table 9 – 2018 test results, including final results of those who submitted insufficient evidence before 1 March 2018

<table>
<thead>
<tr>
<th>Initial test results</th>
<th>Jan-18</th>
<th>Mar-18</th>
<th>Jun-18</th>
<th>Sept -18</th>
<th>Total</th>
<th>Total %age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pass</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>13</td>
<td>65%</td>
</tr>
<tr>
<td>Fail</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>7</td>
<td>35%</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>20</td>
<td>100%</td>
</tr>
</tbody>
</table>
What this tells us
Almost half of candidates passed the Test of Competence initially, that figure rose to 66% once the assessment of those submitting further evidence was completed. The pass rate is in line with the previous version of the test, but lower than in previous years and since commencement of the new format test.

Figure 8 - number of candidates passed vs number of those candidates now registered

What this tells us
Figure 8 shows the time lag between candidates passing the test and being granted registration. This is of interest as it means no registration fees are received from candidates for some time and often not in the year they passed. This is partly due to applicants needing to obtain current documentation for their registration applications and subsequent processing by the GCC office.

Table 10 – percentage failure rate per year since 2015

<table>
<thead>
<tr>
<th>Month of test</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>50</td>
<td>25</td>
<td>50</td>
<td>56</td>
</tr>
<tr>
<td>March</td>
<td>14</td>
<td>50</td>
<td>0</td>
<td>33</td>
</tr>
<tr>
<td>June</td>
<td>44</td>
<td>44</td>
<td>27</td>
<td>20</td>
</tr>
<tr>
<td>September</td>
<td>28</td>
<td>33</td>
<td>13</td>
<td>0</td>
</tr>
</tbody>
</table>

What this tells us
The failure rate of the test produces an interesting pattern with the highest failure rate in January. This is of interest as it is the January test that is often the most popular and therefore a failure rate of 56% represents a large number of candidates failing. Also, when reviewing those five candidates who failed in January 2018 it is noteworthy that only one has since sat the test again.
**Insufficient evidence**

Of the 7 candidates asked to submit further evidence all have now done so and have passed the test, bringing the final pass rate for 2018 to 66%. In total, further evidence was required on 15 subjects, split between 7 candidates, so several candidates were weak in multiple subject areas. Candidates required to submit further evidence are given six months to undertake additional learning and submit evidence. The most recurring subjects are given below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited knowledge of taking and/or maintaining patient records</td>
<td>3</td>
</tr>
<tr>
<td>Limited knowledge of the management of psychosocial factors</td>
<td>2</td>
</tr>
<tr>
<td>Consent</td>
<td>2</td>
</tr>
<tr>
<td>Limited knowledge of evidence based care</td>
<td>1</td>
</tr>
<tr>
<td>Limited understanding clinical audit</td>
<td>1</td>
</tr>
<tr>
<td>Limited knowledge of imaging in the UK</td>
<td>1</td>
</tr>
<tr>
<td>Limited understanding of clinical risk factors</td>
<td>1</td>
</tr>
<tr>
<td>Limited understanding of safeguarding</td>
<td>1</td>
</tr>
<tr>
<td>Limited knowledge of Cauda Equina Syndrome</td>
<td>1</td>
</tr>
<tr>
<td>Insufficient understanding of outcomes</td>
<td>1</td>
</tr>
<tr>
<td>Poor understanding of the health needs of patients</td>
<td>1</td>
</tr>
<tr>
<td>Total number of subjects for 2018</td>
<td>15</td>
</tr>
</tbody>
</table>

**What this tells us**

Three out of the 7 candidates where required to submit further evidence around patient records. Limited knowledge of the management of psychosocial factors was the second highest subject area requiring additional information, which was incidentally the same number as for 2017. Overall there was a wide range of subjects covered only once and therefore no definite conclusions can be drawn.
Figure 9 – number of candidates passing the test following submission of additional evidence

What this tells us
All candidates required to submit additional evidence have since both passed the test and gone on to register. This is noteworthy as the number of those who passed after providing further evidence was higher than those who passed without doing so.

Nationality of test candidates
Figure 10 - nationality of test candidates

What this tells us
Almost half of the 2018 test candidates were either American or Australian, which follows past experience. In 2017, 7 candidates were EU nationals (excluding UK nationals), while in 2018 only one candidate was from the EU as the applicant didn’t meet the requirements of applying through the EU General Directive (See page 19). With the UK leaving the EU during 2019, we may see an increase in applications from EU nationals in the first instance as they seek registration before the deadline. However, given that we receive few applications via the EU General Directive we are unlikely to see a large increase in numbers.
What this tells us
The numbers applying from individual countries varies year on year, however we generally receive applications from Australians, Americans, Canadians, South Africans and New Zealanders. Numbers applying from New Zealand have dropped over the past few years and in 2018 we received no applications from New Zealand nationals. Also the number of EU nationals has fallen back from a peak in 2017, which indicates that figure was a blip rather than a trend. This figure may rise in future years after the UK leaves the EU and those nationals may need to pass the test before applying for registration. This will depend on how the UK leaves the EU and whether provisions are in place to allow EU nationals to apply via a non-Test of Competence route.

Qualification of applicants
Figure 12 – number of candidates per college in 2018

<table>
<thead>
<tr>
<th>College</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand College of Chiropractic</td>
<td>3</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>University of Johannesburg</td>
<td>3</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Murdoch University</td>
<td></td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Palmer College of Chiropractic</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durban University of Technology</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New York Chiropractic College</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southern California University of Health Sciences</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal Melbourne Institute of Technology</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canadian Memorial Chiropractic College</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Logan College of Chiropractic</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What this tells us
The number of applicants is spread much more evenly between the various colleges than previously and the number of candidates from any one college is small.

Figure 13 - comparison of colleges since 2014

What this tells us
Little is discernible by the comparison other than that no candidates came from Macquarie University in 2018 and which had previously provided a high number of candidates. Also a small number of candidates were received from Life University graduates in the previous four years, but none for 2018. What emerges are the single figure applications for many of the US colleges and which was true even with a higher number of applicants.
What this tells us
There was a significant decrease in numbers from both US and Australian colleges of at least 50% and although numbers generally for 2018 were down, figures for New Zealand and South Africa were less marked.

Applicants applying under European Union (EU) General Directive 2005/36/EC

Establishment (route 3)
The GCC registered five applicants through the EU General Directive in 2018, which is slightly fewer than the past six years, but higher than 2017.

Those five registrants applied on the basis that they held EU community rights, were established to practise as chiropractors in a member state of the EEA and intended practising within the UK on a permanent basis; referred to in the Directive as ‘establishment’.
What this tells us
While there are more new registrants through the EU General Directive in 2018 than 2017, numbers have not increased to those seen since 2016. The effect of the UK exiting the EU is currently unknown, but the GCC may see a last minute influx of applications before exit day or conversely see no applications at all. While there are a number of scenarios that could play out, all of which would allow applications received prior to exit day to be processed as normal should they pass exit day before a decision is made.

Table 12 – educational institution of applicants through the EU directive in 2018

<table>
<thead>
<tr>
<th>Educational institution</th>
<th>Country</th>
<th>Number of registrants</th>
<th>Year of graduation (total graduates in brackets)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insitut Franco-Européen de Chiropraxie (IFEC)</td>
<td>France</td>
<td>3</td>
<td>2012, 2016, 2017</td>
</tr>
<tr>
<td>Barcelona College of Chiropractic</td>
<td>Spain</td>
<td>1</td>
<td>2015</td>
</tr>
<tr>
<td>Canadian Memorial Chiropractic College</td>
<td>Canada</td>
<td>1</td>
<td>2000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>5</strong></td>
<td></td>
</tr>
</tbody>
</table>

Table 13 – nationality of applicants through the EU General Directive

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Number of registrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>French</td>
<td>3</td>
</tr>
<tr>
<td>Portuguese</td>
<td>1</td>
</tr>
<tr>
<td>Swiss</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5</strong></td>
</tr>
</tbody>
</table>

What this tells us
Given the small number of applicants through the EU General Directive during 2017, no conclusions can be drawn from the data, which is given here for completeness. Although to note that the majority of candidates came with a French qualification as we have seen in the past.

Temporary and occasional registration (route 4)
The GCC did not grant registration to any applicants on the basis of temporary and occasional registration during 2018.
**Trends in initial registration**

The following section gives an indication of future trends in the potential number of graduates who may apply for GCC registration over the next five years. The focus is on graduates from the UK colleges offering accredited courses, who make up the largest number of new registrants each year.

We have not estimated the number of students dropping out of courses before graduation. This is both because the numbers are small, but we have also observed small increases in student numbers in the past.

### Table 14 – potential graduates with recognised qualifications for the next five years

<table>
<thead>
<tr>
<th>Educational institution</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglo-European College of Chiropractic</td>
<td>104</td>
<td>110</td>
<td>119</td>
<td>125</td>
<td>130</td>
</tr>
<tr>
<td>University of South Wales</td>
<td>57</td>
<td>65</td>
<td>94</td>
<td>105</td>
<td>105</td>
</tr>
<tr>
<td>McTimoney College of Chiropractic</td>
<td>39</td>
<td>44</td>
<td>44</td>
<td>49</td>
<td>36</td>
</tr>
<tr>
<td>South Bank London University</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>15</td>
<td>32</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>200</strong></td>
<td><strong>219</strong></td>
<td><strong>257</strong></td>
<td><strong>294</strong></td>
<td><strong>303</strong></td>
</tr>
</tbody>
</table>

What this tells us

In 2018 there were 178 UK graduates, significantly lower than the 207 who graduated in 2017. This low figure will increase again each year over the next five years, representing a 50% increase over a relatively short period. On current forecasts there are likely to be in the region of 125 more graduates in 2023 than in 2018.

### Table 15 – projected registration figures for the next five years

<table>
<thead>
<tr>
<th>Educational institution</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK graduates*</td>
<td>134</td>
<td>146</td>
<td>172</td>
<td>194</td>
<td>203</td>
</tr>
<tr>
<td>Foreign Qualified**</td>
<td>19</td>
<td>19</td>
<td>19</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>EU Directive**</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>156</strong></td>
<td><strong>165</strong></td>
<td><strong>191</strong></td>
<td><strong>213</strong></td>
<td><strong>222</strong></td>
</tr>
</tbody>
</table>

* these figures have been calculated based on a registration rate of 66% for UK graduates.
** these figures have been calculated based on the number of registrants through these route to registration in 2017. Figures through the EU General Directive are shown as zero from 2020 onwards as it’s unclear at the time of writing whether a comparable alternative will be implemented or whether applicants will have to follow the foreign qualified route.

What this tells us

Based on the projections shown in figure 13, we anticipate a similar number of initial registrants in 2019, but the following few years there are likely to small increases, with a potential jump to over 200 in 2022. Given there is a potential then for an increase of in the region of 60 applications, most of whom are likely to apply during the peak July and August
period, there may be an impact on office workload during that period that should be considered at the time.

**Retentions**

**Summary**

This section covers the 2018 retention period for the 2019 registration year, which began in mid October and concluded on 15 December 2018.

Each year the GCC is required to ask all registered chiropractors to complete a retention application form and pay the fee to remain registered for the following year by the statutory deadline of 30 November.

Factors affecting annual retention figures and income include those:

- choosing to paying the non-practising fee
- lapsing from the register, or applying for voluntary removal, at the end of the retention period on 15 December; and
- registering for the first time on or after 10 November, so as only to pay the fee for initial registration and not also for retention.

**Non-practising registration fee**

Schedule 2 of the GCC (Registration) Rules 1999, allows a registrant not intending to practise as a chiropractor in the UK for the following registration year in full, to pay a reduced fee of £100.

Where a registrant pays the non-practising rate his or her register entry is annotated, so those seeking treatment can differentiate between registrants practising and those who are not.

By the end of December 2018, 233 chiropractors (7.2% of the profession) paid the non-practising fee having declared they did not intend practising in the UK at all during 2018.
Figure 16 – percentage of registrants paying the non-practising fee since 2012

What this tells us
Figure 24 gives the percentage of the register population paying the non-practising fee over the past five years. The figure for 2018 shows another decrease in the overall percentage and the lowest recorded since 2015. We continue to make it clear to those wishing to register or retain by paying the non-practising rate, that this is only appropriate in the short-term. We spoke to several registrants who wished to pay the lower fee during the retention period and, after advising them of their options, they chose to allow their registration to lapse.

Retainers paying the non-practising fee
Of those 233 paying the non-practising fee, 230 did so through retention and the remaining three were registered from 10 November 2017. The fee for those registering after 10 November is considered as income for the following year as the fee covers registration through to the end of the following year.

The various reasons given for paying the non-practising fee are considered below.

Table 16 - reasons given for paying the non-practising registration fee

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of registrants</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working overseas</td>
<td>134</td>
<td>58.0</td>
</tr>
<tr>
<td>Maternity/ Child care</td>
<td>27</td>
<td>12.0</td>
</tr>
<tr>
<td>Not working as a chiropractor</td>
<td>26</td>
<td>11.0</td>
</tr>
<tr>
<td>Sabbatical</td>
<td>16</td>
<td>7.0</td>
</tr>
<tr>
<td>Academic</td>
<td>10</td>
<td>4.0</td>
</tr>
<tr>
<td>Studying</td>
<td>8</td>
<td>3.5</td>
</tr>
<tr>
<td>Travelling</td>
<td>4</td>
<td>1.5</td>
</tr>
</tbody>
</table>
Report on the 2018 GCC registration year

| Role as carer | 3 | 1.0 |
| Health | 3 | 1.0 |
| Retired | 2 | 1.0 |
| Total | 233 |

What this tells us
70% of registrants paying the non-practising fee did so as they were either practising outside of the GCC’s jurisdiction or were taking a career break for maternity or child care reasons. The table shows that there are a number of categories of registrants not practising who do not need to remain registered, in particular those retired, with health issues, travelling, or who are caring for others. The inclusion of ten academics who are actively working in a chiropractic environment, but who fail to pay the full fee annually also raises a question that the GCC will consider during 2019.

Removals from the register
Continued registration depends on compliance with all registration requirements and failure to comply may lead to removal from the register.

Removal from the register can be for any of the following reasons:

Failure to remain fit to practise (struck-off)
Registrants may be removed from the register if they do not meet the standards set out in The Code: Standards of Performance, Conduct and Ethics for Chiropractors, or comply with GCC legislation.

Failure to retain on the register (lapse)
All registrants must provide a retention application form and pay the fee before the retention statutory deadline of 30 November each year. If a complete application is not received by the due date a final warning notice is issued allowing registrants a further 14 days to comply. If at the end of the notice period the application has not arrived the registrant is normally removed from the register.

Failure to complete annual CPD requirements (CPD non compliance)
Each year all registrants must return a completed CPD summary, giving details of the learning they undertook that year in compliance with our CPD rules and guidance. Registrants not providing a summary, or who fail to meet CPD requirements, may be removed from the register.

Voluntary removal
The GCC rules allow registrants to voluntarily apply to remove their name from the register at any time by submitting an application form and a statutory declaration. The declaration is an undertaking signed by the registrant confirming that they are not aware of
any matters that could give rise to a future complaint. The Registrar has a discretionary power to refuse to remove a registrant from the register, such as where there are disciplinary matters outstanding.

<table>
<thead>
<tr>
<th></th>
<th>Struck off</th>
<th>Lapse</th>
<th>Voluntary</th>
<th>Deceased</th>
<th>CPD non compliance</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>February</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>March</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>April</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>May</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>June</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>July</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>August</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>September</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>October</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>47</td>
<td>52</td>
</tr>
<tr>
<td>November</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>December</td>
<td>0</td>
<td>65</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>79</td>
</tr>
<tr>
<td><strong>2018</strong></td>
<td><strong>1</strong></td>
<td><strong>71</strong></td>
<td><strong>28</strong></td>
<td><strong>4</strong></td>
<td><strong>47</strong></td>
<td><strong>151</strong></td>
</tr>
<tr>
<td><strong>2017</strong></td>
<td><strong>1</strong></td>
<td><strong>83</strong></td>
<td><strong>14</strong></td>
<td><strong>4</strong></td>
<td><strong>55</strong></td>
<td><strong>157</strong></td>
</tr>
<tr>
<td><strong>2016</strong></td>
<td><strong>1</strong></td>
<td><strong>80</strong></td>
<td><strong>21</strong></td>
<td><strong>4</strong></td>
<td><strong>39</strong></td>
<td><strong>145</strong></td>
</tr>
<tr>
<td><strong>2015</strong></td>
<td><strong>1</strong></td>
<td><strong>44</strong></td>
<td><strong>21</strong></td>
<td><strong>2</strong></td>
<td><strong>25</strong></td>
<td><strong>81</strong></td>
</tr>
<tr>
<td><strong>2014</strong></td>
<td><strong>3</strong></td>
<td><strong>39</strong></td>
<td><strong>21</strong></td>
<td><strong>2</strong></td>
<td><strong>42</strong></td>
<td><strong>107</strong></td>
</tr>
</tbody>
</table>

What this tells us

Table 17 shows that the majority of removals from the register normally fall in October at the end of the CPD period and following the retention deadline in December. The remaining removals occur throughout the year and are largely made up of those taking voluntary removal from the register. The GCC’s Professional Conduct Committee ‘struck-off’ one registrant in 2018.

The number of removals from the register in 2018 was comparable to 2017, although more registrants took voluntary removal than previously. The numbers for those failing to submit CPD summaries or retention applications fell by a small degree.

Reasons for no longer remaining on the register

Most registrants do not formally notify us of their reasons for coming off the register, and these figures are therefore collated from voluntary removal applications, email correspondence and last known addresses.
Table 18 – reasons for no longer remaining registered

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of registrants</th>
<th>%age of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overseas</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>Unknown</td>
<td>39</td>
<td>26</td>
</tr>
<tr>
<td>Retired</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Not working as a chiropractor</td>
<td>14</td>
<td>9.5</td>
</tr>
<tr>
<td>Health</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Missed deadline</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Child care</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Career Change</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Deceased</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Family reasons</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Pregnancy/ Maternity</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Sabbatical</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Struck-off</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Personal reasons</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Travel</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Total</td>
<td>151</td>
<td>100%</td>
</tr>
</tbody>
</table>

What this tells us
Registrants leave the register each year for a variety of reasons. Excluding those for whom we have no data, chiropractors no longer residing in the UK formed the largest category and made up 40% of registrants. The figures themselves do not show anything of concern, although the total number of leavers should be reviewed annually to understand whether there are trends requiring further investigation.

Table 19 – 2017 fees paid by 2018 leavers

<table>
<thead>
<tr>
<th></th>
<th>Number of registrants</th>
<th>As a %age of removers</th>
<th>%age of the register</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practising</td>
<td>95</td>
<td>63</td>
<td>92.8</td>
</tr>
<tr>
<td>Non-practising</td>
<td>55</td>
<td>37</td>
<td>7.2</td>
</tr>
</tbody>
</table>

What this tells us
A higher percentage of leavers during 2017 had paid the non-practising fee for the year than the profession as a whole. There still remains some hesitancy by registrants to relinquish
registration initially even though those not practising do not need to remain registered. There is still a perception that restoring to the register is a complicated process including passing the Test of Competence, although this has never been the case.

<table>
<thead>
<tr>
<th>Reason for removal</th>
<th>Practising</th>
<th>Non Practising</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPD non compliance</td>
<td>18 (38%)</td>
<td>29 (62%)</td>
<td>47</td>
</tr>
<tr>
<td>Lapse</td>
<td>49 (69%)</td>
<td>22 (31%)</td>
<td>71</td>
</tr>
<tr>
<td>Struck off</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Voluntary removal</td>
<td>24 (86%)</td>
<td>4 (14%)</td>
<td>28</td>
</tr>
<tr>
<td>Deceased</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

What this tells us
Table 20 compares the registration fee paid by those leaving the register by the reason for their removal. Of particular interest is the 62% removed for failure to submit a CPD summary who had paid the non-practising fee. Figures from 2015 to 2017 were 64%, 51% and 42% respectively showing some fluctuations although both the number and percentage of those non-practising for 2018 was only marginally higher than for 2017. We may then have expected to see the percentage of those lapsing with non-practising registration reduce from the 2017 figure, but in fact the percentage remained the same.
Diversity of the register

New registrants
Data collected on initial registration application forms includes sex and date of birth. The GCC separately allows applicants and registrants to provide details of other protected characteristics; data for which is given below.

Split by sex of new registrants
The following data shows the split by sex, of those registered during 2018.

Figure 17 – sex of new registrants

What this tells us
The split between the sexes of those registering for the first time in 2018 was an almost a reversal of 2017 figures.
Age split of new registrants
The following chart shows the age split of all new registrants between 2013 and 2018.

Figure 18 – percentage split of new registrants by age since 2013

What this tells us
The under 30 group made up the bulk of new registrants as expected since the majority are new graduates, and which has increased over the past few years. This appears to be at the expense of the 30-44 bracket, the figure for which has dropped from 33% in 2013 to 20% in 2018.

Ethnicity
Figure 19 - percentage split of new registrants by ethnic
Religion/ belief
Figure 20 – percentage split of new registrants by religion/ belief

Sexual orientation
Figure 21 – Sexual orientation

Split of the register by sex
Figures 22 – percentage split of registrants by sex since 2006
What this tells us
While there is a near 50:50 split between female and male chiropractors, male chiropractors currently outnumber their female colleagues by a tiny fraction of less than half a percent. There being 9 more male chiropractors than female.

Split of the register by age

Figure 23 – percentage split of registrants by age since 2006

![Graph showing percentage split of registrants by age since 2006]

Figure 24 – percentage split of registrants by age since 2006

![Graph showing percentage split of registrants by age since 2006]

What this tells us
The age split of those registered remains relatively static, with a very gradual increase in the number of registrants over 45. The reason for this is unclear, but it may in part relate to the beginning of regulation of chiropractic education in the UK and also the requirements for overseas applicants having deterred some chiropractors from applying.
**Other protected characteristics**
The following charts give the percentages of registrants who identify with protected characteristics. The percentage of the register population who have not provided details are also included.

**Figure 25** - percentage of the profession identifying as disabled

- No: 69.20%
- Yes: 29.70%
- Prefer not to say: 0.80%
- No response: 0.30%

**Figure 26** - percentage of registrants identifying with the same gender as at birth

- No: 68.04%
- Yes: 31.72%
- Prefer not to say: 0.06%
- Blank: 0.18%
Figure 27 – Sexual orientation

- Bisexual: 0.60%
- Gay man: 0.20%
- Gay woman: 0.60%
- Heterosexual: 28.90%
- Prefer not to say: 0.60%
- No response: 0.80%

Figure 28 - Religion/ belief

- Buddhist: 0.60%
- Christian: 13.20%
- Hindu: 0.40%
- Jewish: 0.40%
- Muslim: 0.20%
- None: 11.50%
- Other: 1.80%
- Prefer not to say: 1.50%

Figure 29 - Ethnicity

- Asian: 2.69%
- Black: 0.61%
- Chinese: 0.70%
- Mixed: 1.32%
- No response: 0.61%
- Other: 0.70%
- Prefer not to say: 0.92%
- White: 67.77%
- Mixed: 25.93%

Other registrations work
A review of registration processes along with the database began in the fourth quarter of 2018 and will form the foundation for work to be undertaken during 2019. This will look at all registration processes with a view to understand where changes can be made to streamline and remove unnecessary procedures.

CPD
The Registration and Education Teams completed an 18 month audit of 2015/16 CPD summaries as well as smaller audits for the two subsequent CPD years. The audits were difficult at times for both the office and registrants but highlighted issues within the CPD scheme; learning that will feed into the review of CPD and which will result in a more proportionate system.

Revised guidance
During the year the Registrations Team revised its guidance, including on English Language Skills, CPD for 2018/19 and the Test of Competence mapping document.

Fee for provision of Certificates of Current Professional Status
At its meeting in April 2018 Council agreed with a proposal to charge a fee of £50 for provision of Certificates of Current Professional Status for registrants, which are sent to other regulators to inform them of the status of a GCC registered chiropractor. This was to ensure the cost is recovered for the additional work created for processing the certificate.

For further information, please contact:
Registrations team
General Chiropractic Council
Park House, 186 Kennington Park Road
London, SE11 4BT
020 7713 5155 x5501/ x5513
www.gcc-uk.org
registrations@gcc-uk.org
1. Purpose

The purpose of this paper is to provide an annual update to Council on Equality, Diversity and Inclusion (EDI) activities for 2018.

2. Background

The GCC has a duty to comply with the Equality Act 2010 and is committed to valuing equality and diversity and to providing equality of opportunity.

Under the Equality Act 2010 we must have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by the Equality Act 2010;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The Equality Act covers nine ‘protected characteristics’: age; disability; gender reassignment; race; religion or belief; sex; sexual orientation; marriage and civil partnership; and pregnancy and maternity.

In 2015, the GCC agreed six EDI objectives. These are:

- Objective 1 – Governance
  
  To ensure that Equality, Diversity and Inclusion is effectively embedded in the Council’s decision-making and in its membership

- Objective 2 – Policies and Processes
  
  To develop and implement policies and processes that are fair, transparent and comply with the law and best practice

- Objective 3 – Data
  
  To improve the collection and analysis of equality data in order to enhance our decision-making and future planning

- Objective 4 – Employment
  
  To attract, develop and retain a diverse, skilled workforce
Objective 5 – Communications and Engagement

_to ensure that the GCC communicates and engages in ways that is accessible to all_

Objective 6 – Access

_to ensure that access to GCC information is available to all_

3. Progress

Objective 1 – Governance: To ensure that Equality, Diversity and Inclusion is effectively embedded in the Council’s decision-making and in its membership

As part of the GCC’s work on EDI, several Unconscious Bias training workshops were provided by learning and development specialists Amber and Greene for staff, Council, Fitness to Practise Committees, Test of Competence assessors and education visitors. Each training session was tailored to the roles and responsibilities of each group and the feedback from participants was that they had found the workshops both beneficial and relevant to the work they undertake for the GCC.

Council also held a workshop to agree how it will ensure the new GCC values and behaviours (see Objective 4) are supported and demonstrated within the GCC’s work culture.

From this work, Council agreed three priorities:

- Strengthening relationships between Council members and staff
- Sharing more information with staff from Council meetings and ensuring that there are opportunities to hear staff views
- Holding each other to account, evaluating Council meetings and listening to feedback.

The recruitment process for all committees is carried out in accordance with EDI principles with identifying data being anonymised or redacted.

Objective 2 – Policies and Processes: To develop and implement policies and processes that are fair, transparent and comply with the law and best practice

The GCC is committed to developing and implementing policies and processes that are fair, transparent and comply with the law and with best practice. As part of the GCC’s ongoing work on improving our work culture, a revised Equality and Diversity HR policy was drafted, along with all other staff policies. Once completed, these will form part of a completely new set of staff policies in the organisation. An updated staff handbook is also in draft and will include updated sections on EDI and EDI expectations in the workplace.

Equality impact assessments are considered when new projects are initiated and new policies are formulated. Equality implications are built into any high level issues that require a decision for the Council.

Objective 3 – Data: To improve the collection and analysis of equality data in order to enhance our decision-making and future planning

The GCC routinely collects registrants’ equality data and in 2018, 74% of registrants completed...
the equality and diversity monitoring form. See the annex for Demographics for the profession.

The GCC is currently in the process of creating a new registrant database and will consider if there is any additional data that needs to be routinely requested or collected in order to enhance our understanding of the profession and for our future decision-making.

Objective 4 – Employment: To attract, develop and retain a diverse, skilled workforce

Throughout 2018 staff engagement was a high priority. Staff took part in workshops to develop a set of values and behaviours that would be agreed by staff and carried forward into everything we do.

The agreed values are:

- **Togetherness** – to work as a team in the GCC and with others, appreciate diversity and differences of opinion, listen effectively and support each other
- **Achievement** – to work hard to a common goal, encourage and support staff, foster continuous improvement and innovation, celebrate success
- **Accountable** – to take responsibility, use resources wisely to fulfil the regulatory duties, set clear attainable targets
- **Integrity** – to communicate openly and honestly, building mutual respect and trust and having an open mind to reflect and learn lessons.

Staff discussed the importance of valuing and appreciating diversity and difference and discussed ways to create a working environment that embraced and embedded those values. The new values have since been included in staff appraisals and have also featured as part of the interview process for staff recruitment.

The recruitment process for a new Chief Executive and Registrar began in late 2018 and was carried out by an external agency committed to the EDI "unlimited for all" values.

Three new registrant education visitors were recruited in May 2018 following an internal recruitment process. Applicants were selected for interview by panels made up of Council, Committee members and an external panel member. All equality and diversity information was removed from application forms prior to the shortlisting process to ensure that the selection panels were unaware of applicants’ equality data.

In 2018 the GCC moved the office to a new location, leasing premises from the Health and Care Professions Council (HCPC) in Kennington. The new premises provide a shared space where events such as World Mental Health day raised awareness and provided information promoting mental wellness. The building also features a designated prayer room.

Objective 5 – Communications and Engagement: To ensure that the GCC communicates and engages in ways that is accessible to all

The GCC continues to be represented at the joint healthcare regulators equality, diversity and inclusion forum. The forum provides an opportunity for regulators to share ideas and current projects with others.
We aim for our consultations, surveys and research projects address equality and diversity issues and that we gather information from a broad and diverse range of respondents.

The GCC is currently working closely with a communications agency to better engage with the public, chiropractors and our stakeholders. As part of this work, we will aim to ensure that any communication is accessible to all groups.

Objective 6 – Access: To ensure that access to GCC information is available to all

In accordance with the Equality Act 2010, ‘Reasonable adjustments’ are offered across the organisation.

GCC publications are available in large text and key publications are available in Welsh.

The GCC also offers, where required, an interpreter/translation service as part of the hearings process.

Forward planning

In 2018 the GCC replaced the 2018 - 2020 strategy with a new GCC five year strategy (2019 – 2023). As such, the objectives will be appraised and updated in order to align with the latest GCC strategy and we will continue to review our equality considerations in the organisation to ensure that we continue to learn and improve on our role as a fair and transparent regulator.

4. Action required

Council is asked to note the report.

5. Financial implications

There are no financial implications arising from this paper.

6. Legal or Risk Implications

There are legal implications of this report. We must comply with the Equality Act 2010 as mentioned above.

7. Equality Implications

There are equality implications as set out in the paper.

8. Communications Implications

There may be communication implications arising from this paper, such as how we communicate any changes we make to our EDI objectives and/or strategy.
Annex

Demographics

Below are the demographics for that we hold for the profession.

Sex

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Male</td>
<td>50%</td>
</tr>
<tr>
<td>Female</td>
<td>50%</td>
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Age

<table>
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<tbody>
<tr>
<td>Under 30</td>
<td>16%</td>
</tr>
<tr>
<td>30 – 44</td>
<td>42%</td>
</tr>
<tr>
<td>45 – 59</td>
<td>33%</td>
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<tr>
<td>Over 60</td>
<td>9%</td>
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Disability

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<tbody>
<tr>
<td>No</td>
<td>69%</td>
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<tr>
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<td>Less than 1%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>Less than 1%</td>
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<tr>
<td>No response</td>
<td>30%</td>
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Sexual Orientation

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<tbody>
<tr>
<td>Bisexual</td>
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<tr>
<td>Gay man</td>
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<tr>
<td>Gay woman</td>
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<tr>
<td>Heterosexual</td>
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<tr>
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<tr>
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<td>68.90%</td>
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Religion or belief

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<tbody>
<tr>
<td>Buddhist</td>
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<tr>
<td>Christian</td>
<td>13.20%</td>
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<tr>
<td>Hindu</td>
<td>0.30%</td>
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<tr>
<td>Jewish</td>
<td>0.20%</td>
</tr>
<tr>
<td>Muslim</td>
<td>0.40%</td>
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<tr>
<td>None</td>
<td>13.00%</td>
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<tr>
<td>Other</td>
<td>1.50%</td>
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<tr>
<td>Prefer not to say</td>
<td>1.80%</td>
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<tr>
<td>Sikh</td>
<td>0.40%</td>
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<tr>
<td>No response</td>
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Race

<table>
<thead>
<tr>
<th>Race</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Asian</td>
<td>2.69%</td>
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<tr>
<td>Black</td>
<td>0.61%</td>
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<tr>
<td>Chinese</td>
<td>0.70%</td>
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<td>Mixed</td>
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<tr>
<td>Other</td>
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<td>0.06%</td>
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<tr>
<td>White</td>
<td>67.77%</td>
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Gender reassignment

<table>
<thead>
<tr>
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<tbody>
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<td>0.06%</td>
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<tr>
<td>Yes</td>
<td>31.72%</td>
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<tr>
<td>Prefer not to say</td>
<td>0.18%</td>
</tr>
<tr>
<td>No response</td>
<td>68.04%</td>
</tr>
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</table>

We do not hold data on pregnancy/maternity.

We do not hold data on marriage/civil partnership.