**General Chiropractic Council meeting**

**Time and Date:** 10am, Thursday 10 March  
**Venue:** Premier Meetings London Euston  
1 Duke's Road  
London WC1H 9PJ

**OPEN AGENDA**

**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>
<th>Action</th>
<th>Presenter</th>
<th>Paper</th>
<th>Timing</th>
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<tbody>
<tr>
<td>1.</td>
<td>Apologies and declarations of interest</td>
<td>to note</td>
<td>Chair</td>
<td>10.00</td>
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<td>2.</td>
<td>Draft minutes of meeting of 3rd December 2015 and matters arising</td>
<td>to approve to note</td>
<td>Chair</td>
<td>1603/2 1603/2a</td>
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<td>3.</td>
<td>Chair’s report</td>
<td>to note</td>
<td>Chair</td>
<td>10.15</td>
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| 4. | **Chief Executive’s report**  
   a. Advertising, including guidance on the use of the title ‘Dr’  
   b. Non-practising register  
   c. Increase in complaints on advertising  
   d. Update on RCC annual meeting  
   e. Meeting with Department of Health on legislation | to note | CER | 1603/4a | 10.30 |
| 5. | **Governance Review**  
   a. Complaints against members of Council  
   b. Grievance and Disciplinary policies  
   c. Governance manual | to note to agree to agree | CER | 1603/5a | 10.50 |
| 6. | The Code - Guidance notes | to approve | Dir.Education | 1603/6 | 11.20 |
| 7. | Audit Committee report and review of Strategic Risk Register | to note | DCE Chair Audit Ctte | 1603/7 | 11.35 |
| 8. | Performance Report | to note | DCE | 1603/8 | 11.45 |
| 9. | Update from Remuneration Committee | to note | Chair Remuneration Ctte | 1603/9 | 12.00 |
| 10. | Council work plan | to note | Chair | 1603/10 | 12.05 |
| 11. | AOB | | Chair | | 12.10 |

**Date of next meeting:** 16 June 2016
MINUTES OF THE MEETING
OF THE GENERAL CHIROPRACTIC COUNCIL
HELD ON 3 DECEMBER 2015
44 WICKLOW STREET, LONDON WC1X 9HL

OPEN SESSION

Present:
Suzanne McCarthy, Chair
Sophia Adams Bhatti
Marie Cashley
Roger Creedon
Roger Dunshea
Tom Greenway
Gareth Lloyd
Julie McKay
Grahame Pope
Liz Qua
Julia Sayers
Carl Stychin
Gay Swait
Phil Yalden

In attendance:
David Howell, Chief Executive and Registrar
Penny Bance, Director of Education, Registration and Standards
Paul Ghuman, Deputy Chief Executive (Director Resources & Regulation)
Neil Johnson, Policy and Communications Manager
Amanda Greenlees, Executive PA

Apologies and declarations of interest
There were no apologies and no declarations of interest.

C-031215-1 Draft minutes of the meeting of 30 September 2015
The minutes were agreed as a correct record of the meeting of 30 September 2015.

C-031215-2 Matters arising and action log
The Director of Education, Registration and Standards provided an update on the guidance notes, saying they were currently out for consultation. She also said there had been a very good response to the consultation. The closing date was imminent and responses would be analysed and the guidance notes finalised. The final draft guidance notes would be brought to Council for approval in March 2016.

It was noted that the Governance manual had been sent to Council members for
comment.
All other actions were completed.

**Action:** Approval of guidance notes to be put on the Council March agenda.

<table>
<thead>
<tr>
<th>C-031215-3</th>
<th>Chair's report</th>
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<tr>
<td><strong>Meeting with Ben Gummer on 9th December</strong></td>
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<td>The Chair notified Council that a meeting had been set up with Ben Gummer MP on December 9th, which she and the Chief Executive (CE) would be attending. An update would be provided to Council following the meeting.</td>
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<td><strong>Appraisals</strong></td>
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<td>The Chair would be carrying out member appraisals as well as the Council effectiveness survey and would meet with Council members in January and February of 2016.</td>
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<td><strong>Joint GCC/RCC/Professional Associations meeting</strong></td>
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<td>The Chair mentioned the upcoming joint GCC/RCC/Joint Associations meeting and Council noted that the registrant member who would be attending the January meeting was Tom Greenway.</td>
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<td><strong>Action:</strong> Update on meeting with Ministers to be provided to Council</td>
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<tr>
<th>C-031215-4</th>
<th>Chief Executive's Report</th>
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<td><strong>Update on Guidance notes</strong></td>
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<td>An update on this had been provided under 'matters arising' in the open session.</td>
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<td><strong>Use of the title 'Dr'</strong></td>
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<tr>
<td>The CE discussed the professions’ use of the title ‘Dr’. The current position was that the courtesy title could be used by chiropractors providing they were clear and were not misleading the public when advertising. The Committee of Advertising Practice (CAP) who write the Code of Practice for the Advertising Standards Authority agreed that there was no problem with chiropractors using the title as long as they followed the GCC’s stipulations and made it clear they were not medical doctors, where they were not.</td>
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<td><strong>Presentation</strong></td>
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<td>The CE gave a presentation on the Year in Review, covering such topics as Council’s newly agreed three-category approach to advertising. The presentation also covered the latest independent FtP audit review, which showed that the concerns highlighted by the PSA had been resolved.</td>
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<td>The CE said there had been a reduction in the number of complaints reported to the GCC and noted the addition of a Registrations Appeals Committee, which would also cover any appeals from the Test of Competence.</td>
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<td>The CE discussed additional projects such as the Governance manual, which had recently been sent to Council for comment, the annual GCC and FtP reports, the revision of the Equality and Diversity policy which had now been agreed, and a new complaints procedure.</td>
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Council congratulated and thanked the GCC team for all their work and the improvements made in the areas covered in the year review.

Review of Strategic Aims and Business Plan

Business Plan 2016
Council discussed and reviewed the GCC Business Plan and Strategic Aims for 2016. The Deputy Chief Executive (DCE) said that the GCC’s focus in 2016 would be on activities that encompassed and would improve the GCC’s core functions. One of the GCC's main focus points would be reviewing and agreeing the requirements for any future Healthcare Bill. This initial work would allow the GCC to progress the drafting of any secondary legislation in a timely manner.

Regarding the Operational plan, Council was advised that reports on progress against the operational plan were provided in the monthly performance reports. The DCE also agreed to provide an indication in the Performance report of what stage the GCC were at in relation to specific projects.

Education Committee Annual Report

The Chair of the Education Committee provided Council with a report on the work undertaken by the Education Committee in 2015.

He spoke of the recent meeting which took place with the Professional Associations and Royal College of Chiropractors (RCC) to discuss the ToC, which he reported as having been very positive. The meeting had been organised to discuss concerns raised around delivery of the ToC.

In addition to the regular Committee meetings, a workshop had been held on the Code of Practice and Standards of Proficiency and the review of CPD. The Education Committee had recommended that the new integrated Masters qualification from the AECC be recognised.

He reported that the Committee had appointed an external consultant to review and update the Degree Recognition Criteria and Quality Assurance procedures. A workshop on the topic had been held at the Education Committee’s recent meeting.

The Director of Education, Registration and Standards reported on Assuring Continuing Fitness to Practise, saying that development groups had been set up to work with the GCC on the development of a new CPD scheme and in particular, the new aspects of such a scheme. She said that there was a broad range of chiropractors in the volunteer groups and that the groups were proving valuable in providing information about such things as titling and the way the GCC communicates with registrants. She said the discussions had been very positive and she hoped this work would continue beyond the initial time frame. She added that no new scheme could be introduced without legislative change and new CPD Rules.

Communications Plan

The Communications and Policy Manager introduced his paper on Narrative Messages 2016. He noted that at the September Council meeting, all items contained in the Communications plan had been delivered except for the
webinars. Since that time, two webinars had taken place to support the Assuring Continuing Fitness to Practise development workshops.

The Communications Manager had started discussions with the Associations and the RCC. The Chair and CE had also attended several conferences and events. He said the GCC planned to engage with charities and patient groups relevant to the chiropractic profession in 2016. It was also planned that the newsletter would be published on a monthly basis over 2016.

He also discussed the new Code, saying it was important that the GCC communicated the point that the new Code had been developed in conjunction with the profession.

**Annual Report**

Council would be sent the Annual Report, due to be released early the following week. The Policy and Communications Manager said he welcomed views from Council for incorporation into future reports. In response to a comment about timing of the report, it was noted that the 2015 Annual Report will be published in October 2016.

**Action:** Council members to be send the GCC 2014 Annual Report

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<tr>
<th>C-031215-8</th>
<th>Remuneration Committee Report</th>
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<td><strong>The Chair of the Remuneration Committee provided an update to Council on the recent Remuneration Committee meeting.</strong> She said the Committee had look at benchmarking across the board and had agreed a 2% pay award to all staff, with a further discretionary 1% award, which would be based on merit.</td>
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<td>She said that an external advisor was carrying out a similar task on benchmarking for Council members, Chair and Committee members and that an update would be provided once the report from the external advisor had been received.</td>
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<td>The Committee had also discussed healthcare options for staff. The Committee felt more work needed to be done before coming to a final decision so that costs to both individual staff members and the organisation could be fully considered. The Committee had asked the CE to research some of the options provided.</td>
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<td><strong>Action:</strong> Update on benchmarking for Council, Chair and Committee members to be provided to Council when report was available</td>
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<tr>
<th>C-300915-9</th>
<th>Presentation from Cazenove</th>
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<td><strong>Jeremy Barker and Rory Cummings from Cazenove provided Council with an update on the portfolio to enable Council to make an informed decision about the portfolio in the discussion on the Investment Strategy Review (item 10).</strong></td>
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<td>Cazenove presented the performance of the portfolio over the last 12 months. Council noted that the portfolio was very diverse and that performance against other benchmarks was comparable. Cazenove reported on recent market turmoil and advised that they were looking to identify any opportunities in the current market. They also said it would be reasonable to expect a 3% income return from the portfolio.</td>
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Cazenove requested that they be advised of any changes to the current drawdown requirements, in order that the portfolio could be re-structured to try and meet those demands.

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<tr>
<th>C-300915-10</th>
<th><strong>Investment Strategy Review</strong></th>
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<tr>
<td>Council reviewed the current investment policy which was agreed in August 2013.</td>
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<td>Taking into account the discussion previously had with the investment managers, Cazenove, Council decided that there was no requirement to amend the strategy and that it should be reviewed again in 12 months’ time.</td>
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<td>The minor changes were to remove reference to a previous Committee of Council and to specify the return as being inflation plus 4%.</td>
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<td>Council approved the investment strategy for 2016.</td>
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<th>C-300915-11</th>
<th><strong>Budget 2016</strong></th>
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<td>The DCE introduced the Draft Budget for 2016. He began by reminding Council of the efficiency measures that had been agreed some years ago and which had reduced expenditure by 50% from 2010 to December 2015.</td>
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<td>He noted that the percentage of actual graduates registering with the GCC had reduced, due to the level of overseas students who, upon graduation, went on to register within another European country. As such, the income budget had been adjusted for 2016 and also for future years.</td>
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<td>There were no further changes from the draft budget presented in September.</td>
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<td>Council agreed the budget for 2016 and congratulated the GCC team on the significant savings made thus far.</td>
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<tr>
<th>C-300915-12</th>
<th><strong>Financial options and Reserves policy</strong></th>
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<tr>
<td>The DCE introduced the paper on the Reserves Policy. He explained that the policy had been put in place to ensure that the GCC has sufficient funds to carry out its statutory functions and that Council needed to decide whether to agree the current reserves policy or amend it.</td>
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<td>The DCE felt that a somewhat prudent approach would be the best way forward and that it would be important to maintain reserve levels to cover any reduction in income from registrants, or in case of other events which might have a significant event on the organisation.</td>
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<tr>
<td>Council agreed a reduction in the reserve level from £3.6 to £2.9m. At its meeting in March Council would agree a strategy and timeframe for reduction of the reserves.</td>
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**Action:** Financial options to be added to the March 2016 agenda

| C-300915-13 | **Performance Report** |
The DCE introduced the Performance Report for 2015. He said the pipeline of PCC cases had dropped by over 50% since the start of the year. However, as a result of determining large numbers of old cases, the KPI of listing PCC hearings within nine months of referral had not been met in 2015. It was expected that this KPI would be met in 2016 as a result of the reduction of the number of old cases.

The DCE reported that the majority of activities due to be delivered by the end of Quarter 3 had progressed as planned. There had been some delays to the approval of The Code which meant that the associated guidance work would be completed later than anticipated.

As at October 2015, there was a surplus of £7k and the estimated year-end position was forecast to be a deficit of £82k.

### Report from the Audit Committee

The Chair of the Audit Committee said that the minutes from the meeting on November 4th would be released shortly. The Audit Committee felt that the strategic risks had been reduced and that the recent FtP audit reports assured the Committee that substantial progress had been made in resolving concerns raised by the PSA.

### Procedures for dealing with complaints against GCC Council members

The Chair and Chief Executive, along with an external consultant, had been working on a procedure for dealing with complaints. Council felt some further amendments could be made and agreed this would be given a final review by the external consultant. Council also agreed that members should be sent the document for final comment before presenting the final version to Council in March.

**Action:** After final review by the CER and consultant the policy to be sent to Council members ahead of the March meeting.

### Draft 2016 work plan

Council agreed the draft work plan for 2016.

**Date of next meeting:** 10 March 2016
## ACTIONS ARISING FROM THE COUNCIL MEETING OF DECEMBER 2015

<table>
<thead>
<tr>
<th>ITEM</th>
<th>ACTION</th>
<th>STATUS</th>
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<tbody>
<tr>
<td>2.1</td>
<td>Approval of guidance notes to be put on the Council March agenda.</td>
<td>on agenda</td>
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<tr>
<td>3.1</td>
<td>Update on meeting with Minister (Ben Gummer) to be provided to Council</td>
<td>on agenda</td>
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<tr>
<td>7.1</td>
<td>Council members to be sent the GCC 2014 Annual Report</td>
<td>completed</td>
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<tr>
<td>8.1</td>
<td>Update on benchmarking for Council, Chair and Committee members to be provided to Council when report is available</td>
<td>on agenda</td>
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<tr>
<td>12.1</td>
<td>Financial options item to be added to the March 2016 agenda</td>
<td>on agenda</td>
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<tr>
<td>15.1</td>
<td>After final review by the CER and legal advisor, complaints policy to be sent to Council members ahead of the March meeting.</td>
<td>update to be provided at March Council meeting</td>
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To: GCC Council
From: David Howell, Chief Executive
Subject: Advertising Guidance
Date: 10th March 2016

Purpose

1 The purpose of this paper is to provide Council with an update on the discussions between the GCC and the Committee of Advertising Practice (CAP) on the use of the courtesy title ‘Dr’.

Background

2 The reason for the GCC discussions is that, contrary to our own Code, the CAP’s guidance indicated that Chiropractors should not use the courtesy title ‘Dr’ at all in advertising, even if they make it clear that they are not medically qualified. However, the CAP took a different approach in their guidance to dentists, which states that a practitioner’s advertisement needs to state clearly and prominently, close to the practitioner’s title and qualifications, that the title ‘Dr’ is a courtesy title and that the practitioner does not hold a general medical qualification.

Updated position

3 Following discussions the CAP has concluded that it cannot justify having a different rule for dentists than for chiropractors and has amended its online guidance, which is published on its website as follows:

Use of the term "Dr": Chiropractors

Note: This advice is given by the CAP Executive about non-broadcast advertising. It does not constitute legal advice. It does not bind CAP, CAP advisory panels or the Advertising Standards Authority.

Advertisers wanting to refer to themselves as “Dr”, “a doctor” or similar, should take care not to imply that they hold a general medical qualification if they do not. The need for clarity is greatest when marketers are making health-related claims and the ASA has taken a tough line on marketers making unqualified reference to the ‘Dr’ title in the context of health.

The ASA has upheld complaints against ads for chiropractors that have misleadingly implied that the advertiser is a medical practitioner. Advertisers should note that references to “DC” or “doctor of chiropractic” are unlikely to dispel that misleading impression, when used in conjunction with unqualified references to the prefix ‘Dr’ (BritChiro Clinics Ltd, 17 September 2008). In 2010, the ASA ruled that a clinic had misleadingly implied that their members of staff were medically qualified. It said that
claims such as “The chiropractic doctors at the Pain Resource Centre...” and “doctors and chiropractors” suggested that staff held general medical qualifications (Phillip Bennetts, 6 October 2010).

CAP understands that the General Chiropractic Council (GCC) permits its members to use the title “Dr” provided the copy makes clear it is a courtesy title only and does not otherwise imply that they hold a general medical qualification (unless they hold a dual registration with General Medical Council (GMC)). The ASA has yet to rule on this matter, however, CAP considers that if the title is clearly and prominently qualified with additional text which makes clear it is a courtesy title and the practitioner does not hold a general medical qualification, reference to the “Dr” title may be acceptable.

Updated 3/12/2015

4 The GCC’s position is that chiropractors are advised to follow the CAP’s guidance and this is clear in the current Code of Practice and Standard of Proficiency and the new Code of Practice, which takes effect in June 2016.

5 Council should note that a breach of the Code does not automatically result in fitness to practise proceedings and that the GCC’s policy is to look at each individual case to see if the public interest is affected.

Recommendation

6 Council is invited to note the change in the CAP’s online guidance, which brings the CAP in line with the GCC’s current position. The Professional Associations have been informed of this and the January newsletter included an item on this.
PROCEDURE FOR DEALING WITH COMPLAINTS
AGAINST MEMBERS OF THE COUNCIL OF THE GCC

3A: General principles

3.1 This procedure is intended to deal with any complaints raised against any Council Member(s) ("the Relevant Member"), whether by any other Member(s), any employee(s) or officer(s) of the GCC, or any third party or parties. It is designed to establish the facts promptly and to deal consistently with complaints that may arise.

3.2 Time limits stated in this procedure are for guidance only and may be extended if the person leading the relevant stage (such as informal resolution, formal investigation, formal hearing or appeal) considers it appropriate to do so.

3.3 In this section 3, Council** means the Council without the Relevant Member, any Accompanying Member and any Appeal Accompanying Member. The term "Member" means a member of Council.

3.4 A Relevant Member must take all reasonable steps to attend any meetings to which they are invited under this procedure.

3.5 Any complaints and details of any informal resolutions should be placed on file along with a record of any decisions taken, any appeal notice, the outcome of any appeal, and any relevant notes or other documents compiled during the complaint process. These will be kept and processed in accordance with our Data Protection Policy, but subject to:

(a) any legal or regulatory requirements, and/or

(b) the Chair of the Audit Committee, the Chair of Council or the Council** reasonably considering that any details should be disclosed to one or more third parties.

3.6 In the event of any formal hearing and/or any appeal hearing under this procedure, these will normally be held in private unless determined otherwise (acting reasonably) by whoever is leading that particular aspect of the process (namely the Investigator or whoever is hearing the appeal).

3B: Receipt of a complaint against a Member

3.7 Any complaint against a Member should be made in writing to the Chair of Council. If a complaint is received by another Member, or an officer or employee of the GCC, it should be forwarded to the Chair of Council as soon as reasonably practicable.

3.8 Alternatively, if the complaint is about the Chair of Council, it should be addressed or forwarded to the Chair of the Audit Committee.

3.9 If an oral complaint is received, the complainant should be asked to put this in writing. If the complainant is unable or unwilling to do so, the person receiving the complaint should note it as best they can, and this will be taken forward as the written complaint.

3C: Passing to the Chair of the Audit Committee

3.10 Upon receiving a written complaint about a Member, the Chair of Council will pass it to the Chair of the Audit Committee.
Alternatively, if the complaint is about the Chair of the Audit Committee, the Chair of Council will pass it to another Member chosen by the Chair of Council. If this occurs, the references (below) to "the Chair of Audit Committee" which are marked * shall be taken to refer to that alternative Member.

3D: Approach to complaint

3.12 The Chair of the Audit Committee* will pursue whichever of the following approaches they consider, at their discretion, to be appropriate:

(a) adopt the formal process set out in section 3E onwards, below;
(b) dismiss the complaint;
(c) take whatever steps he/she considers appropriate, to seek to resolve the complaint informally; or
(d) nominate another Member, a GCC employee, or an external person to seek an informal resolution of the complaint.

3.13 In choosing between options (a) - (d), the Chair of the Audit Committee* may seek further information from the complainant and/or the Relevant Member.

3.14 The Chair of the Audit Committee* will notify the Chair of Council, the Relevant Member, and the complainant of the chosen course of action.

3.15 If options (c) or (d) are pursued, and are unsuccessful, the Chair of the Audit Committee* will choose again from options (a) and (b).

3.16 Discussions to reach an informal resolution would normally be held in private.

3.17 If an informal resolution is reached, the Relevant Member, the complainant and the Chair of Council will be informed in writing.

3.18 Ordinarily details of an informal resolution will not be reported to Council unless the Chair of Council considers it necessary in the circumstances.

3.19 In what he/she reasonably considers to be exceptional circumstances, the Chair of the Audit Committee* may vary this section 3D as appropriate to a particular case, in relation to matters over which they have responsibility.

3E: Formal investigation

3.20 The Chair of the Audit Committee* will investigate the complaint, or will appoint an external Investigator to do so. In either case, the person investigating is referred to below as "the Investigator".

3.21 The Investigator may, at his or her discretion, appoint others to assist the investigation, such as another Member, an employee or officer of the GCC, or a third party.

3.22 The purpose of an investigation is to establish a fair and balanced view of the facts relating to the complaint. This may involve reviewing any relevant documents and emails, interviewing the relevant individuals, taking witness statements, and such other enquiries as the Investigator considers appropriate. The nature and extent of the investigation will depend on
the nature of the allegations and will vary from case to case. It is likely to include a meeting with the Relevant Member. It may also include meeting or speaking with the complainant.

3.23 The Relevant Member must co-operate fully and promptly with any investigation. This will include informing the Investigator of the names of any witnesses, disclosing any relevant documents, and attending investigative meetings if requested to do so by the Investigator.

3.24 In what he/she reasonably considers to be exceptional circumstances, the Investigator may vary this section 3E as appropriate to a particular case.

3F: Formal hearing

3.25 The Investigator will conduct a formal hearing. The purpose of the formal hearing is to review the evidence and enable the Relevant Member to respond formally to the allegations. The Investigator will also discuss other relevant aspects of the investigation, and the evidence this has produced, to the extent that the Investigator considers it appropriate to do so.

3.26 In advance of the formal hearing, the Investigator shall formally notify the Relevant Member in writing of the allegations and the basis for those allegations. This may include, at the Investigator's discretion, such material as:

(a) a summary of relevant information gathered during the investigation;
(b) documents which will be relied on at the formal hearing; and/or
(c) witness statements which will be used at the formal hearing, except where the Investigator considers it appropriate to keep the witness's identity confidential (in which case the Investigator will give the Relevant Member as much information as possible while maintaining that confidentiality).

3.27 The Investigator will give the Relevant Member written notice of the date, time and location of the formal hearing. The Relevant Member will be given no less than five working days to prepare their case, based on the information which the Investigator has provided.

3.28 The Investigator may decide to ask any other relevant person whom they consider appropriate to attend the formal hearing, and the Investigator may question them and discuss the complaint with them. The Member may advise the Investigator of issues to raise with others, and the Investigator may, at his/her discretion, do so.

3.29 If the Relevant Member would like particular people to attend the formal hearing, he/she can propose this to the Investigator, but must do so sufficiently in advance of the formal hearing, and their attendance will be at the discretion of the Investigator.

3.30 The Relevant Member will have a right to be accompanied at the formal hearing by another Member who has not been involved in the complaint or process to date ("an Accompanying Member"). The Accompanying Member will not act as an advocate nor speak on the Relevant Member's behalf.

3.31 The Investigator may adjourn the formal hearing at any time, for example if the Investigator considers it appropriate to carry out further investigation in the light of points that have arisen.

3.32 If there is an adjournment of the formal hearing, and further investigation, the Relevant Member will be given such details of that investigation as the Investigator considers appropriate and necessary for the satisfactory completion of the formal hearing process. The
Relevant Member will also be given a reasonable amount of time, usually not less than five working days, to prepare their case based on that further information, before the formal hearing reconvenes.

3.33 In what he/she reasonably considers to be exceptional circumstances, the Chair of the Audit Committee* or the Investigator may vary this section 3F as appropriate to a particular case. An example of such a variation which they may consider, would be a request by the Relevant Member to be legally represented (in place of the Accompanying Member), and in considering such a request, the Chair of the Audit Committee* and the Investigator will take account of such issues as they consider relevant (which may include the seriousness of the allegations against the Relevant Member and whether these could have significant implications for the Relevant Member's career or professional standing).

3G: Finding

3.34 The Investigator will reach a provisional decision about the complaint, and will do so on the balance of probabilities. The Investigator will record this decision in a draft report.

3.35 If the draft report upholds all or any aspects of the complaint, it will also specify a proposed sanction to be applied, from the list (a)-(g) in clause 3.40 below.

3.36 A copy of the draft report will be sent to the Chair of Council, the Relevant Member and (if the Investigator considers it appropriate, due to exceptional circumstances) the complainant. If the Investigator is not the Chair of the Audit Committee*, a copy will also be sent to the Chair of the Audit Committee*.

3.37 The complainant (if he/she is sent a copy) and the Relevant Member will be given five working days in which to make written comments or representations to the Investigator about the contents of the draft report.

3.38 The Investigator will consider any such comments or representations received from those to whom the draft report has been given, and finalise his/her decision, the report and the proposed sanction(s) (if any), and send it to the Chair of Council and (if the Investigator is not the Chair of the Audit Committee*) to the Chair of the Audit Committee*.

3.39 In what he/she reasonably considers to be exceptional circumstances, the Chair of the Audit Committee* may (for example, upon a request by the Investigator) vary this section 3G as appropriate to a particular case.

3H: Sanctions

3.40 If the Investigator finds that a Relevant Member has breached the GCC’s Code of Conduct or their conduct otherwise falls below the standards expected of a Member, the available sanctions are:

(a) instructions or advice to the Relevant Member regarding their future conduct ("Sanction (a)");

(b) a warning to the Relevant Member, short of recommending suspension or removal as a Member ("Sanction (b)");

(c) provisional suspension of the Relevant Member, as provided for by section 2 above and article 7 of the Order, and a recommendation to the Privy Council that the Relevant Member shall be suspended from membership of the Council in accordance
with article 7 of the Order, together with a recommended period of suspension ("Sanction (c)"");

(d) provisional suspension of the Relevant Member, as provided for by section 2 above and article 7 of the Order, and a recommendation to the Privy Council that the Relevant Member shall be removed from membership of the Council in accordance with articles 6 and 7(5) of the Order ("Sanction (d)");

(e) informal resolution, as referred to in 3.12(c) or 3.12(d), above;

(f) any other sanction which the Investigator (or, if the Investigator is not a Member, the Chair of the Audit Committee*) considers appropriate in the circumstances ("Sanction (e)"; or

(g) no sanction.

3.41 In what they reasonably consider to be exceptional circumstances, the Chair of the Audit Committee* or the Council** may vary this section 3H as appropriate to a particular case.

3I: Right of appeal

3.42 If the Relevant Member is dissatisfied with the findings of the report and/or the sanction(s), the Relevant Member may appeal in writing within five working days after he/she has received both the report and notification of the sanction(s). In doing so, the Relevant Member should detail the reason(s) for the appeal.

3.43 For the avoidance of doubt, the complainant has no right of appeal. However, if they are a GCC employee, they have access to the GCC grievance procedure.

3.44 In what he/she reasonably considers to be exceptional circumstances (for example, reasonable grounds for delay by the Relevant Member in lodging an appeal), the Chair of Council may vary this section 3I as appropriate to a particular case.

3J: Appeal process

3.45 Subject to paragraph 3.46 below, the appeal will be heard by the Chair of Council. He/she may decide instead that the appeal will be heard by an appeal panel, consisting of another Member (who has not been materially involved in the complaint) and an external third party, both of whom shall be chosen by the Chair of Council.

3.46 If the complaint is against the Chair of Council, the appeal will be heard by a three-person panel consisting of the longest serving Member (ignoring the Chair of Council, the Chair of Audit and any Member who has been materially involved in the complaint), and that Member's chosen other Member (who has not been materially involved in the complaint) and chosen external third party.

3.47 Whoever is hearing the appeal will decide what form the appeal hearing will take, such as a re-hearing, a paper consideration, or otherwise. Generally an appeal will at least entail a meeting with the Relevant Member, although this is not essential. In exercising their discretion on format, whoever is hearing the appeal will take note of the grounds of the appeal, the circumstances of the case and any new information that has come to light since the original decision. An example of a change in format which they may consider, would be a request by the Relevant Member to be legally represented (in place of the Appeal Accompanying Member, as defined below), and in considering such a request, whoever is hearing the appeal will take account of such issues as they consider relevant (which may
include the seriousness of the allegations against the Relevant Member and whether these could have significant implications for the Relevant Member's career or professional standing).

3.48 Whoever is hearing the appeal may choose to take further evidence from whoever they wish and consider any other evidence which they consider appropriate.

3.49 The Relevant Member will have a right to be accompanied at the appeal hearing, by "an Appeal Accompanying Member", who can be the Accompanying Member or another Member who has not been involved in the complaint or process to date. The Appeal Accompanying Member will not act as an advocate nor speak on the Relevant Member's behalf.

3.50 Whoever hears the appeal will reach a decision on the balance of probabilities, to:

(a) confirm the original decision and sanction(s);
(b) increase the sanction(s);
(c) reduce the sanction(s);
(d) reverse the finding against the Relevant Member, in whole or part;
(e) make detail corrections to the original decision, such as correcting dates or other obvious factual errors, without altering the outcome or sanction;
(f) send the matter back to the Investigator for further or fresh consideration;
(g) or decide such other outcome as whoever hears the appeal considers appropriate.

3.51 Unless there are exceptional circumstances such as an appeal process which reveals a need for further extensive investigations by those deciding the appeal, the Relevant Member will be informed in writing of the decision of the appeal hearing within ten working days of the appeal hearing. However, this timescale is indicative only.

3.52 The written decision of the appeal is final, and no further appeal may be made. The only exception to this principle is if the appeal decision was to send the matter back for further consideration by the Investigator: in those circumstances, any revised decision by the Investigator will be subject to a fresh right of appeal under this section 3J.

3.53 In what they reasonably consider to be exceptional circumstances, the Council** may vary this section 3J as appropriate to a particular case.

3K: Implementation of any penalty against a Relevant Member

3.54 If the Investigator is the Chair of the Audit Committee* and he/she decides upon Sanction (a), Sanction (b) or Sanction (e), he/she will impose this sanction once the deadline for an appeal has passed without any appeal being received.

3.55 If the Investigator is not the Chair of the Audit Committee* and he/she decides upon Sanction (a), Sanction (b) or Sanction (e), the Chair of the Audit Committee* will impose this sanction once the deadline for an appeal has passed without any appeal being received.

3.56 If an appeal hearer decides to impose or approve Sanction (a), Sanction (b) or Sanction (e), he/she will impose this sanction once the appeal process is complete.
3.57 If the Investigator is the Chair of the Audit Committee* and he/she decides upon Sanction (c) or Sanction (d), then once the deadline for an appeal has passed without any appeal being received he/she will notify the Chair who will ask the Privy Council to suspend (in the case of Sanction (c)) or remove (in the case of Sanction (d)) the Relevant Member from the Council.

3.58 If the Investigator is not the Chair of the Audit Committee* and he/she decides upon Sanction (c) or Sanction (d), then once the deadline for an appeal has passed without any appeal being received, the Chair of the Audit Committee* (unless he/she considers there to be exceptional circumstances warranting informal resolution or a different Sanction, in which case he/she will attempt that informal resolution, impose that different Sanction or notify the Relevant Member that he/she is unilaterally granting an extension to the deadline for appealing) will notify the Chair who will ask the Privy Council to suspend (in the case of Sanction (c)) or remove (in the case of Sanction (d)) the Relevant Member from the Council.

3.59 If an appeal hearer decides to impose or approve Sanction (c) or Sanction (d), then once the appeal process is complete he/she will notify the Chair who will ask the Privy Council to suspend (in the case of Sanction (c)) or remove (in the case of Sanction (d)) the Relevant Member from the Council.

3.60 In what they reasonably consider to be exceptional circumstances, the Chair of the Audit Committee* or the Council** may vary this section 3K as appropriate to a particular case.
To: The GCC Council
From: Penny Bance, Director of Education, Registration and Standards
Subject: Development and publication of guidance for the new Code
Date: 10th March 2016

Purpose
1. The purpose of this paper is to seek approval from the Council on six guidance notes.

Introduction
2. The Code of Practice and Standard of Proficiency (CoP and SoP) has been reviewed and a new and updated Code was approved by Council in June 2015. This Code comes into effect on 30th June 2016.

3. In March 2015 Council agreed to the development of separate guidance in six key areas to help registrants understand and inform their actions:
   - Maintaining sexual boundaries
   - Consent
   - Candour
   - Confidentiality
   - The use of social media
   - Advertising

4. Pye Tait Consulting were commissioned to develop the guidance notes and input was sought from legal experts during drafting and post consultation. Council members gave their detailed comments ahead of the public consultation.

Consultation
5. Online consultation ran for five weeks from 5th November 2015 until 10th December 2015 and sought views on the draft guidance notes. In total 241 consultation responses were received. Some respondents chose to take the opportunity of commenting on more than one piece of guidance. A feature of the survey was that respondents could respond on one, several or all of the guidance notes.

6. The majority (95%) of respondents were responding as an individual with the remainder (5%) responding on behalf of their organisation, two respondents did not answer this question. Of the 228 individual responses received, the majority (95%) were from chiropractors, 2% were chiropractic students, 1% other healthcare professionals, 1% members of the public and the remaining 1% are classed as ‘other’. See Appendix 1 for further detail.
Communication
7. The guidance notes will be available online and will be monitored and kept under review. Registrants will be expected to follow the guidance, to use their professional judgement, demonstrate insight at all times and be able to justify any decision that is not in line with the guidance.

8. It is planned to publish the guidance notes ahead of the new Code coming into effect.

Equality Implications
9. Equality and diversity issues have been considered throughout the review project.

Communications Implications
10. A communications and implementation plan has been developed for the new Code and will be expanded to include the guidance notes.

Action required
The Council is asked to approve the six guidance notes.
Appendix 1: Guidance Consultation Analysis, December 2015

**Context**

A new and updated Code, which sets out the values and professional behaviours required by chiropractors, is due to come into effect on 30th June 2016. From that date, chiropractors will have to meet the requirements of the new Code. It does not contain guidance, instead separate guidance has been developed to accompany certain standards which appear in the Code.

The purpose of the consultation was to seek views on the draft guidance documents which are to be read in conjunction with the Code. There are six sets of guidance notes involved in this consultation.

Pye Tait Consulting carried out this consultation on behalf of the GCC. Pye Tait Consulting is an independent market research agency bound by the Market Research Society and registered under the Data Protection Act. All responses to the consultation survey were analysed and considered post consultation.

The consultation ran online for a total of five weeks from 5th November until 10th December 2015.

**Summary of consultation responses**

In total 241 valid consultation responses were received. Response levels for each Guidance document vary as some respondents chose to take the opportunity of commenting on more than one piece of Guidance. This was a feature of the survey that respondents could respond on one, several or all of the Guidance.

The percentage and count of completions per Guidance document are presented below:

<table>
<thead>
<tr>
<th>Guidance</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advertising</td>
<td>44%</td>
<td>106 completions</td>
</tr>
<tr>
<td>Candour</td>
<td>44%</td>
<td>105 completions</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>35%</td>
<td>85 completions</td>
</tr>
<tr>
<td>Consent</td>
<td>41%</td>
<td>98 completions</td>
</tr>
<tr>
<td>Sexual Boundaries</td>
<td>33%</td>
<td>79 completions</td>
</tr>
<tr>
<td>Social Media</td>
<td>40%</td>
<td>97 completions</td>
</tr>
</tbody>
</table>
The number and percentage of documents commented on per respondent:

<table>
<thead>
<tr>
<th>Documents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>151 (63%)</td>
</tr>
<tr>
<td>2</td>
<td>17 (7%)</td>
</tr>
<tr>
<td>3</td>
<td>13 (5%)</td>
</tr>
<tr>
<td>4</td>
<td>3 (1%)</td>
</tr>
<tr>
<td>5</td>
<td>8 (3%)</td>
</tr>
<tr>
<td>6</td>
<td>49 (20%)</td>
</tr>
</tbody>
</table>

The majority (95%) of respondents were responding as an individual with the remainder (5%) responding on behalf of their organisation, two respondents did not answer this question. Of the 228 individual responses received, the majority (95%) are from chiropractors, 2% are chiropractic students, 1% are other healthcare professionals, 1% are members of the public and the remaining 1% do not fall into any of these categories and are classed as ‘other’.

**Guidance documents**

**Advertising**

92% of respondents believe that the Guidance on advertising is helpful and useful

82% also believe that the Guidance is easy to understand.

**Respondents were asked whether they thought there was anything else that this piece of Guidance should cover, which it currently does not.** 66% responded ‘no’, and 21% responded ‘don’t know’. Those who responded ‘yes’ were asked to explain what else they would expected to see. Of the 13% who responded ‘yes’ a number of different comments were provided.

**Respondents were then asked if certain paragraphs within the Guidance make clear what is expected.** A few comments were received on particular paragraphs and a few general comments were given in the final comments section.

**Candour**

85% of respondents believe that the Guidance on candour is helpful and useful

85% also believe that the Guidance is easy to understand.

**Respondents were asked whether they thought there was anything else that this piece of Guidance should cover, which it currently does not.** 71% responded ‘no’, and 16% responded ‘don’t know’. Those who responded ‘yes’ were asked to explain what else they
would expect to see. Of the 13% who responded ‘yes’ a small number of different comments were provided, mainly around the provision of case studies, which is out with this project.

Respondents were then asked if certain paragraphs within the Guidance make clear what is expected. Very few comments were received on particular paragraphs and a few general comments were made in the final comments section.

Confidentiality

95% of respondents believe that the Guidance on confidentiality is helpful and useful
95% also believe that the Guidance is easy to understand.

Respondents were asked whether they thought there was anything else that this piece of Guidance should cover, which it currently does not. 71% responded ‘no’, and 16% responded ‘don’t know’. Those who responded ‘yes’ were asked to explain what else they would expect to see. Of the 13% who responded ‘yes’ a number of individual comments were received.

Respondents were then asked if certain paragraphs within the Guidance make clear what is expected. A few comments were received but most issues had already been covered in the guidance. The final comments section received a range of views.

Consent

83% of respondents believe that the Guidance on consent is helpful and useful.
88% also believe that the Guidance is easy to understand.

Respondents were asked whether they thought there was anything else that this piece of Guidance should cover, which it currently does not. 67% responded ‘no’, and 13% responded ‘don’t know’. Those who responded ‘yes’ were asked to explain what else they would expect to see. Of the 20% who responded ‘yes’ a number of different comments were provided.

Respondents were then asked if certain paragraphs within the Guidance make clear what is expected. A very small number of comments were received. The final comments on Consent section received a range of views, many of which have been actioned.

Maintaining Sexual Boundaries

97% of respondents believe that the Guidance on sexual boundaries is helpful and useful
97% also believe that the Guidance is easy to understand.

Respondents were asked whether they thought there was anything else that this piece of Guidance should cover, which it currently does not. 97% responded ‘no’, and 7% responded ‘don’t know’. Those who responded ‘yes’ were asked to explain what else they would expect to see but only one comment was received.

Respondents were then asked if certain paragraphs within the Guidance make clear what is expected. A very small number of comments were received. The final comments on Sexual Boundaries were from a range of individuals.
The Use of Social Media

86% of respondents believe that the Guidance on social media is helpful and useful.

81% also believe that the Guidance is easy to understand.

Respondents were asked whether they thought there was anything else that this piece of Guidance should cover, which it currently does not. 77% responded ‘no’, and 13% responded ‘don’t know’. Those who responded ‘yes’ were asked to explain what else they would expect to see. Of the 11% who responded ‘yes’ a number of different comments were provided.

Respondents were then asked if certain paragraphs within the Guidance make clear what is expected. A very small number of comments were received. The final comments on Consent section received a range of individual and collective views, many of which required no action.
Guidance on the use of Social Media

This guidance must be read in conjunction with The Code (2016) prepared by the General Chiropractic Council (GCC), which sets out standards for conduct, performance and ethics for chiropractors to ensure the competent and safe practice of chiropractic.

This guidance is not intended to cover every situation that you may face. However, it does set out broad principles to enable you to think through and act professionally, ensuring patient interest and public protection at all times.

To note: The GCC will review this guidance as necessary and update it as appropriate, and reapply the principles from the Code to any critical changes or new situations that may emerge.

Standards within the Code with reference to social media:

**B4:**
Strictly maintain patient confidentiality when communicating publicly or privately, including in any form of social media or when speaking to or writing in the media.

Other Standards in The Code that reinforce and link to the above:

**B3** Use only legal and verifiable information when publicising yourself as a chiropractor, advertising your work and/or your practice including on your website. The information must be honest and comply with all advertising codes and standards.

**B5** Ensure your behaviour is professional at all times, including outside the workplace, thus upholding and protecting the reputation of, and confidence in, the profession and justifying patient trust.
“Social Media” describes web-based applications that allow people to create and exchange content. In this guidance Social Media is used as a portfolio term to include blogs and microblogs (such as Tumblr and Twitter), internet forums (including professional e-forums), content communities (such as YouTube and Flickr), social networking sites (such as Facebook and LinkedIn), and other current or emerging social networking platforms. Any professional e-forum or professional social media site that you may belong to is equally relevant.

The standards expected of chiropractors do not change just because they are communicating with others through social media as opposed to being face-to-face or through other traditional media. However, using social media does create new circumstances in which the established principles of professionalism apply.

As well as this guidance, and the general guidance on confidentiality, you should also create and/or comply with social media policies within your place of work.

**Using social media responsibly**

If used responsibly and appropriately, social networking sites can offer several benefits for chiropractors. These include: building and maintaining professional relationships; establishing or accessing chiropractic support networks; and being able to discuss specific issues, interests, research and clinical experiences with other healthcare professionals globally. In addition, social media, if used properly, is a good way to market yourself as a chiropractor and/or to advertise a chiropractic practice.

To use social media responsibly you must make sure that you keep yourself informed and up-to-date, think before you post and be sensitive to protecting your reputation and that of the profession. This means:

(i) you should familiarise yourself with how individual social media applications work and be clear about their advantages and disadvantages;

(ii) you should realise that even the strictest privacy settings have limitations. This is because once something is online it is not easy to retrieve it and can be easily copied and redistributed by other people; and

(iii) where you are unsure whether something you post online could compromise your professionalism or your reputation, you should think about what the information means for you in practice and how it affects your responsibility to keep to the Code. It is best to err on the side of caution and not to post it.
It is important to consider with whom and with what you associate with on social media. For example, merely acknowledging someone else’s post can imply that you endorse or support their point of view despite any disclaimer you may use.

You must also consider the possibility of other people mentioning you in inappropriate posts. If you have used social media for a number of years, it is important to consider, in relation to the Code, both what you have posted online in the past and what others have posted about you, and whether all posts should remain on your account(s). Equally, remember that anything you or others post about you will likely be online for many years to come.

Privacy

Using social media can blur the boundaries between an individual’s private and professional life. Online information can be easily accessed by others. Chiropractors must be aware of the limitations of privacy online, it is strongly advised that you regularly review the privacy settings for every social media account you have, and adopt conservative privacy settings where these are available. It is important to understand that not all information can be protected on social media and in particular:

(i) social media sites cannot guarantee confidentiality whatever privacy settings are in place;
(ii) patients, your employer and potential employers, or any other organisation that you have a relationship with, may be able to access your personal information;
(iii) information about your location may be embedded within photographs and other content and available for others to see; and
(iv) once information is published online it can be difficult to remove as other users may distribute it further.

Anonymity

You must be aware that content uploaded anonymously can, in many cases, be traced back to its point of origin. Although you may intend to post anonymously, you should be mindful that your comments may in fact be attributed to you in some way.

If you identify yourself as a chiropractor in publicly accessible social media, you must also identify yourself by name. This is because any material written by authors who represent themselves as chiropractors is likely to be taken on trust, and may reasonably be taken to represent the views of the profession more widely. If you are willing to give online information or advice as a member of the profession, then you should be willing to be identified and accountable for that.
Professional behaviour

Chiropractors should be conscious of their online “image” and how it may impact on their professional standing and the reputation of the wider chiropractic profession. As well as any legal proceedings that could follow, you may put your registration at risk if, on any form of social media, (either personal or professional accounts), you act in any way that is unprofessional, or unlawful including (but not limited to):

(i) sharing confidential information;
(ii) posting images of patients and people receiving care (or pictures from which they can be identified) without their consent;
(iii) posting or otherwise permitting inappropriate images of yourself such that your professional reputation or that of the wider profession may be adversely affected;
(iv) posting inappropriate comments about patients or other chiropractors;
(v) bullying, intimidating or exploiting people;
(vi) building or pursuing relationships with patients, ex-patients, or patients’ carers;
(vii) stealing personal information or using someone else’s identity;
(viii) encouraging violence or self-harm; and
(ix) inciting hatred or discrimination.

If you are aware that another chiropractor has used social media in any of these ways, it is your professional duty to report it to the GCC and/or the police. You may find it useful to refer to our guidance note on candour. The note sets out your professional duty to act openly and honestly with patients, regulators and when raising concerns.

When interacting with or commenting about colleagues, other chiropractors or chiropractic practices on social media, you must be aware that online posts are subject to the same laws of copyright and defamation1 as written or verbal communications, whether they are made in a personal or professional capacity. Use of a user name or any form of anonymised identity online does not prevent action from being taken against you or website owners being forced to divulge who you are.

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1 Defamation is the act of making an unjustified statement about a person or organisation that is considered to harm their reputation.
**Maintaining boundaries**

Social media can create risks where social and professional boundaries become unclear. You must ensure your behaviour on social media does not cross professional boundaries.

It is recommended that chiropractors do not accept Facebook friend requests or any other means of communication on other social media forums from current or former patients or patient’s carers on their personal accounts.

If a patient or patient’s carer contacts you about their care or other professional matters through your personal profile, you should indicate that you cannot mix social and professional relationships and, where appropriate, direct them to your professional profile if you have one, or more suitably your professional contact details such as your secure email or telephone number.

You SHOULD not contact or communicate through social media with a patient, or carer, neither in a professional nor personal capacity from a personal account. It is accepted that patients may wish to, or find it more convenient to contact a chiropractor on social media, for example by Facebook messenger or LinkedIn. Any response to a patient on social media should be done through your professional account.

If you currently do not have a professional account where patients and potential patients can contact you for your services, or to which you can direct patients to, we strongly recommend that you create a professional social media account.

By communicating with patients and/or patients carers in a professional manner through your professional account and not your personal account, the risk of misunderstandings and blurring of boundaries are minimised.

**Maintaining confidentiality**

The ethical and legal duty to protect patient confidentiality applies equally to social media as it does when communicating privately or through more traditional means. (You may find it useful to refer to our guidance note on confidentiality).

You must not use social media to discuss individual patients, ex-patients or the treatment of those patients. You may use social media sites that are targeted towards professional communities where current practice and specific (often unusual) but anonymised circumstances are discussed.

While participation in such sites can be very valuable, the requirement to maintain confidentiality and not to share identifiable information about patients...
and ex patients remains. Be aware that it can often be easy to breach this requirement inadvertently (especially if you have a very specialised practice or operate in a small area). If you post lots of information, even if across many different posts it can be possible to identify patients by the sum of information that you make available.

**Other Relevant Information:**


- *Guidance on using social media responsibly, NMC, March 2015,* [www.nmc-uk.org](http://www.nmc-uk.org)

- *Doctors’ use of social media, GMC, March 2013,* [www.gmc-uk.org](http://www.gmc-uk.org)

- *Guidance on Confidentiality, GCC, June 2016,* [www.gcc-uk.org](http://www.gcc-uk.org)
Guidance on Advertising

This guidance must be read in conjunction with The Code (2016) prepared by the General Chiropractic Council (GCC), which sets out standards for conduct, performance and ethics for chiropractors to ensure the competent and safe practice of chiropractic.

This guidance is not intended to cover every situation that you may face. However, it does set out broad principles to enable you to think through and act professionally, ensuring patient interest and public protection at all times.

To note: The GCC will review this guidance as necessary and update it as appropriate, and reapply the principles of the Code to any critical changes or new situations that may emerge.

Standards within the Code with reference to advertising:

**B3:**
Use only legal and verifiable information when publicising yourself as a chiropractor, advertising your work and/or your practice including on your website. The information must be honest and comply with all advertising codes and standards.

Other Standards in the Code that reinforce and link to the above:

**A1**  
Show respect, compassion and care for your patients by listening to them and acknowledging their views and decisions. You must not put any pressure on a patient to accept your advice.

**B2**  
Ensure you, and any chiropractor who works with you on a contractual basis, are properly qualified, registered and insured.
Advertising your chiropractic services or practice is one form of alerting the public and patients to your existence and helping them make informed choices about their healthcare.

It is fundamental that the information you provide is legal, decent, honest and truthful. You must be able to fully substantiate any claims you make at the time they are made, this includes facts about yourself, the work you do, the results of your treatments and the services you provide.

The information you present must be published in a way that conforms to the law, the UK Code of Broadcast Advertising (BCAP code), the CAP Code and guidance issued by the Advertising Standards Authority, the UK’s advertising regulator and Ofcom (please see essential links below).

The information you publish must not make unsubstantiated or false claims about the quality of your services. It must not, in any way, offer guarantees of cures, nor exploit patients' vulnerability or lack of clinical knowledge.

**Advertising services:**

For the purposes of this guidance, advertising includes both broadcast and non-broadcast media, and includes but is not limited to:

(i) all forms of printed and electronic media;
(ii) any public communication using television;
(i) radio;
(ii) newspapers and magazines;
(iii) mobile communications;
(iv) the Internet and websites;
(v) directories;
(vi) business cards; and
(vii) office signs.

Advertising also includes situations in which chiropractors provide information for media reports or articles, including where chiropractors make comment or provide information on particular products or services. You are responsible for the content of any media article, statement or interview in which you are involved or which is attributed to you. Therefore it is advisable for you to ensure that you have seen its content before publication and/or broadcast so that you can ensure it does not breach the Code of Practice or the ASA guidance.

When considering what chiropractic services to offer and therefore advertise, these must only be services that you are qualified to offer, for which you have undertaken the necessary training and obtained the appropriate qualification to be regarded as competent in that skill.

**Authorising the content of advertising**

Chiropractors are responsible for the style and content of all advertising material associated with the provision of their goods and services. You are accountable and responsible for ensuring the accuracy of advertising and compliance
regardless of who writes the material (whether an administrator, manager, director, media or advertising agency or other unregistered person).

If you are an employed chiropractor you may not have direct control over the content of an advertisement. However, you should check and review the content of any advertising of your services and take reasonable steps, such as informing your employer, in writing if necessary, of any aspects that you consider of non-compliance.

Whenever you, your practice or any place where you work as a registrant produces any information linked to your name, you are personally responsible for checking that the information given is correct.

You must:

(i) ensure information is current, accurate and updated if circumstances change;
(ii) use clear language that patients are likely to understand;
(iii) ensure that all claims can be substantiated or independently verified;
(iv) avoid ambiguous statements; and
(v) avoid statements or claims intended and/or likely to create an unjustified expectation about the results you can achieve.

(vi) ensure costs of services are made clear.

It is also highly recommended that your GCC registration number is included with the information listed above.

All of this is important as it is all part of protecting the reputation of, and confidence in, the chiropractic profession as well as ensuring and justifying patient trust.

**Websites**

It is highly recommended that you ensure the website of your practice or the practice in which you work displays the following information:

(i) the name and address at which the chiropractic service is located;
(ii) contact details of the practice, including e-mail address and telephone number; and
(iii) the date the website was last updated.

You must provide details of the practice’s complaints procedure and information that enables patients to contact the GCC in the event of an unresolved complaint.

You should update the information on your website regularly so that it accurately reflects the personnel at the practice and the service offered.
Marketing websites

If you use marketing or social networking websites to promote your services, (e.g. Facebook and Groupon), you must make clear that any treatment advertised is conditional on a clinical assessment being carried out in accordance with the provisions of the Code and that the treatment may not be appropriate for every patient.

Any initial decision by a consumer in response to an advertised service does not imply informed consent and does not remove the obligation on you as a chiropractor to obtain informed consent in writing before proceeding to provide care. You must assess the patient, obtain appropriate consent (see our separate guidance on consent) and discuss the risks as well as the benefits of the options of care.

Use of qualifications and titles

You must not use any title or qualification in a way that may mislead the public as to its meaning or significance.

You must not mislead patients into believing that you are trained and competent to provide other services purely by virtue of your qualification as a healthcare professional.

If you refer to qualifications that you hold in addition to your original chiropractic qualification, you must not say or imply that they are recognised by the GCC as specialist qualifications.

If you use the title ‘Doctor’ in advertising, when talking to patients or in writing such as on business stationery or practice nameplates, you must make it clear that you are not a registered medical practitioner (you should refer to the CAP guidance and the GCC website for further information on this subject).

Suspension from the GCC Register

If you are suspended or removed from the GCC register, it is a criminal offence to say or imply that you are a chiropractor. If you are suspended from the GCC register, you will remain accountable to the GCC during your period of suspension and you are required to remove or amend any advertising material during the period of suspension or on removal from the GCC register.

Essential Reading:


- **UK Code of Broadcast Advertising (BCAP Code)**, [www.cap.org.uk/Advertising-Codes/Broadcast.aspx](http://www.cap.org.uk/Advertising-Codes/Broadcast.aspx)

Additional Information:

• Advertising Standards Authority, www.asa.org.uk/About-ASA/About-regulation.aspx


• Ofcom (Independent regulator and competition authority for the UK communications industries), www.ofcom.org.uk
Guidance on Candour

This guidance must be read in conjunction with The Code (2016) prepared by the General Chiropractic Council (GCC), which sets out standards for conduct, performance and ethics for chiropractors to ensure the competent and safe practice of chiropractic.

This guidance is not intended to cover every situation that you may face. However, it does set out broad principles to enable you to think through and act professionally, ensuring patient interest and public protection at all times.

To note: The GCC will review this guidance as necessary and update it as appropriate, and reapply the principles of the Code to any critical changes or new situations that may emerge.

Standards within the Code with reference to candour:

**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.

Other Standards in The Code that reinforce and link to the above:

**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.
The duty of candour refers to the professional responsibility of openness and honesty required of chiropractors with patients when something goes wrong with their care which causes, or has the potential to cause, harm or distress.

The relationship between a chiropractor and a patient is built on trust, confidence and honesty. Communicating effectively with patients is important as it contributes to establishing and maintaining a professional relationship and it encourages patients to take an informed role in their care.

You must be open and honest with your colleagues, staff and employers in, raising concerns about patients, where appropriate. Support and encourage your colleagues to be open and honest, and do not stop someone from raising any concerns about patients that they may have.

You must take part in reviews and investigations when requested and be open and honest with regulators.

Discussing risks before beginning care

Patients must be fully informed about their care. When discussing with patients the expected outcomes of their care, chiropractors must discuss the risks as well as the benefits and ensure both are fully explained.

You must provide the patient with clear, accurate information about significant risks of the proposed treatment, and the risks of any reasonable alternative options, and ensure that the patient fully understands (see separate Consent guidance). You must discuss significant risks even if very unlikely. You must encourage patients to ask questions and you must answer honestly.

Actions after something has gone wrong with a patient’s care

This guidance is not intended for circumstances where a patient’s condition gets worse due to the progression of a natural illness. It applies when something goes wrong with a patient’s care and they suffer harm or distress as a result. This guidance also applies in situations where a patient may yet suffer harm or distress as a result of something going wrong with their care. After you realise something has gone wrong with a patient’s care, or when the patient raises a concern, you must speak to the patient as soon as possible.

You must follow these steps:

(i) tell the patient (or, where appropriate, the patient’s carer) immediately when something has gone wrong;
(ii) apologise to the patient (or, where appropriate, the patient’s carer);
(iii) offer an appropriate remedy or support to put matters right (if possible); and
(iv) explain fully to the patient (or, where appropriate, the patient’s carer) the short and long term effects of what has happened, what is known and what is expected.

You must share all you know and believe to be true about what went wrong and why and what the consequences are likely to be. You must explain if anything is still uncertain and you must respond honestly to any questions asked. If the patient was caused harm and requires further medical attention, you must take responsibility for referring the patient to someone else for additional care, e.g. their GP or A&E.

**Apologising to the patient**

Patients expect to be told three things as part of an apology:

(i) what happened;
(ii) what can be done to deal with any harm caused; and
(iii) what will be done to prevent someone else being harmed.

When apologising to a patient, you must consider each of the following points:

(i) You must give the patient information they want or need to know in a way that they can understand;
(ii) You must speak to the patient in a place and at a time when they are best able to understand and retain information;
(iii) You must give information that the patient may find distressing in a considerate way, respecting their right to privacy and dignity;
(iv) Patients are likely to find it more meaningful if you offer a personalised apology – for example, ‘I am sorry’ rather than a general expression of regret about the incident on the practice’s behalf;
(v) You must make sure the patient knows who to contact in order to ask any further questions or raise concerns; and
(vi) You must give the patient information about counselling or other support services that can give them practical advice and emotional support.

**Encouraging a learning culture of candour within the workplace**

*Although this is more difficult to put into effect if you work on your own it is good practice to follow these principles.*

In your workplace, it is your duty to encourage a learning culture of candour with colleagues and other health care professionals with whom you may work. You must promote and encourage a culture that allows all to raise concerns openly and without fear of retaliation.
When something goes wrong with patient care, it is crucial that this is reported at an early stage so that lessons can be learnt quickly and patients can be protected from harm in the future. By raising concerns you are protecting patients and ensuring continued public safety.

You must:

(i) be open and honest within your workplace;

(ii) work within the limits of your competence, exercising your professional ‘duty of candour’ and raising concerns immediately whenever you come across situations that put patients or public safety at risk;

(iii) take necessary action to deal with any concerns, where appropriate;

(iv) support staff to report adverse incidents and concerns;

(v) support staff to be open and honest with patients if something goes wrong with their care; and

(vi) not try to prevent colleagues or former colleagues from raising concerns about patient safety.

Additionally if you have membership with the Royal College of Chiropractors or a relevant Chiropractic Association, you could also report any adverse incidents that lead to harm anonymously to the Chiropractic Patient Incident & Learning System (Cpirls).

Websites:


Guidance on Confidentiality

This guidance must be read in conjunction with The Code (2016) prepared by the General Chiropractic Council (GCC), which sets out standards for conduct, performance and ethics for chiropractors to ensure the competent and safe practice of chiropractic.

This guidance is not intended to cover every situation that you may face. However, it does set out broad principles to enable you to think through and act professionally, ensuring patient interest and public protection at all times.

To note: The GCC will review this guidance as necessary and update it as appropriate, and reapply the principles of the Code to any critical changes or new situations that may emerge.

Standards within the Code with reference to confidentiality:

**H1:**
Keep information about patients confidential and avoid improper disclosure of their personal information

Other Standards in The Code that reinforce and link to the above:

**H** Maintain and protect patient information
**H2** Only disclose personal information without patient consent if required by law.

**B4** Strictly maintain patient confidentiality when communicating publicly or privately, including in any form of social media or when speaking to or writing in the media.
Patient confidentiality means that patients, including ex patients, have the right that information about them is kept private. Confidentiality is central to trust between chiropractors and patients. Without assurances about confidentiality, patients may be reluctant to seek treatment and/or to provide you with the information you need in order for you to provide good care. It is your responsibility to maintain and protect the personal patient information you obtain directly or indirectly in the course of your work.

Data protection law

You must abide by data protection law requirements. The Data Protection Act 1998 (the Act) sets out the requirements for handling personal and sensitive personal data as follows:

(i) under the Act, every organisation that processes personal information must notify the Information Commissioner’s Office (ICO) that they do so and have a registered data controller;
(ii) personal data is data that identifies living individuals. Sensitive personal data is information about racial or ethnic origin, political opinions, religious beliefs or other beliefs of a similar nature, membership of a trade union, physical or mental health or condition, sexual life, and the commission or alleged commission of any offence and any related proceedings;
(iii) processing data includes obtaining, recording, storing, using, disclosing information as well as alteration and destruction; and
(iv) the Act applies to all forms of media, including paper and images.

Management of records

You must maintain patient records and store them safely and in good condition for eight years from the date of the patient’s last visit to you or, if the patient is a child, until his or her 25th birthday, or 26th birthday if the patient was 17 at the conclusion of treatment.

Patient records include such information as:
(i) the patient’s personal data;
(ii) the case history of the patient;
(iii) the patient’s consent to assessment and care;
(iv) the assessment and reassessment of the patient’s health and health needs (including the outcomes of further investigations);
(v) the diagnosis or rationale for care (or both);
(vi) the initial and reviewed plans of care for the patient;
(vii) the care provided to the patient (including any advice given face to face or over the phone);
(viii) any referrals;
(ix) clinical images; and
(x) copies of correspondence.
The requirement of eight years is in line with the requirements that cover 
general NHS hospital records and other forms of health records. The purpose of 
this requirement is to make sure that the patient can have access to their recent 
health records and to provide protection for you if any complaints are made.

You must make sure that plans are in place to ensure the safe keeping of patient 
records in the event of your retirement or death (which might include entering 
into a contract with an organisation or other healthcare professional to hold this 
responsibility).

If the responsibility is yours, you must:

(i) Make provision in your will for the safe storage of patients’ records. 
These can then be released to a patient or their legal representative on 
production of the written authority of the patient; and

(ii) in the closing of your practice, you must publicise the arrangements 
that you have made to keep the records safe so that patients know 
how to obtain their records if they want to.

Protecting confidential information

You must effectively protect personal information against improper disclosure. 
You must not disclose information about a patient, including the identity of the 
patient, either during or after the lifetime of the patient, without the consent of 
the patient or the patient’s legal representative.

You must make sure that any personal information about patients that you hold 
or control is effectively protected at all times against improper disclosure.

It is expected that:

(i) neither you nor any members of your staff or colleagues will release 
or discuss personal or care related information about a patient with 
anyone, including their spouse, partner or other family members 
unless you have the patient’s valid consent to do so (see our 
guidance note on Consent);

(ii) patient records are handled in a way that prevents them being 
seen by others;

(iii) paper-based record systems are secure and cannot be accessed 
inappropriately whether you are on or off the premises;

(iv) electronic recording systems are safe from access from outside the 
practice, the security and integrity of data is maintained and the 
system is safely backed-up at regular intervals; and

(v) records are disposed of securely and in a manner that maintains 
patient confidentiality.

The Data Protection Act 1998 requires that:

(i) if you employ a bookkeeper or an accountant, they must be able to see 
the financial information on payments separately from patients’ clinical
records. If members of internal staff are employed to do these jobs, you must still keep both types of information separate;

(ii) if you want to pursue a patient for overdue payments, you must give only the minimum information to outside bodies (for example, for legal action or for debt collection); and

(iii) if you plan to sell or otherwise transfer ownership of your business, every effort must be made to ensure patients are aware that the business is changing hands or for sale (for example through practical activities such as an advertisement in the local paper).

Social Media

Patient confidentiality is not restricted to the workplace or a physical environment. The standards expected of chiropractors do not change just because they are interacting with others through media communications or means of virtual communications. It is incumbent on you and so you are obligated to maintain confidentiality throughout social media usage and communications to the same degree as you are in the physical workplace.

You must ensure patient confidentiality is upheld in all social networking, social media, emails and smartphone applications, including but not limited to:

(i) text messages;
(ii) messaging apps (e.g. Whatsapp, Skype, Facebook); and
(iii) emails.

You must also protect your own privacy and confidentiality. Chiropractors should be aware of the limitations of privacy online. You should regularly review the privacy settings for every social media account you have, and adopt conservative privacy settings where these are available. (See our guidance note on Social Media).

Consent to disclose confidential information

Appropriate information sharing and data collection is essential to the efficient provision of safe, effective care both for individual patients and for the general public. There are times where it may become appropriate to disclose information to another healthcare profession or disclose information for clinical audit or research purposes. Prior to disclosure of any patient information you must seek and record patient consent.

You must:

(i) ensure that patients know about any disclosures necessary for their care or for evaluating and auditing care so they can object to such disclosures if they wish to;

(ii) obtain and record a patient’s express consent before providing personal information about them to others;
(iii) ensure any member of staff working with or for you, understands that they are also bound by a duty of confidence, whether or not they have professional or contractual obligations to protect confidentiality; and

(iv) disclose only the information you need to. It is good practice to anonymise data if this can still serve the purpose of the person asking for the information. This means removing all identifiable information about the patient including, for example, their name, address, date of birth, images or anything else that might serve to identify them.

Disclosure of confidential information without consent

If disclosure is required by law (statutory disclosure), or by a person or authority having a legal power to make such a demand, then you are legally bound to comply.

There are exceptions to the general rule of confidentiality where disclosure can be made to a third party. These are:

(i) if you believe it to be in the patient’s best interests to disclose information to another health professional or relevant agency;

(ii) if you believe that disclosure to someone other than another health professional is essential for the sake of the patient’s health and wellbeing (for example, if the patient is at risk of death or serious harm); or

(iii) if having sought appropriate advice you are advised that disclosure should be made in the public interest (for example, because the patient might cause harm to others).

The disclosure of confidential information in the public interest is only permissible where there are exceptional circumstances that justify overruling the right of the individual to confidentiality because this has to be balanced against the greater societal interest. Decisions about the public interest are complex and must take account of the potential harm that disclosure may cause and the interest of society in the continued provision of confidential health services (for more information see, Department of Health, 2010, Confidentiality: NHS Code of Practice Supplementary Guidance: Public Interest Disclosures, DH, London).

If you make the decision to disclose confidential information, you must, in each case:

(i) inform the patient beforehand as far as this is reasonably practical;

(ii) make clear to the patient what information is to be disclosed, the reason for the disclosure and the likely consequence of the disclosure;

(iii) disclose only the information that is relevant;

(iv) make sure that the person you give the information to holds it on the same terms as those to which you are subject; and
(v) record in writing the reasons for the disclosure, to whom it was made, the information disclosed and the justification for the disclosure.

In certain circumstances you will not be able to tell the patient before the disclosure takes place. Such as when, for example, the likelihood of a violent response is significant, or informing a potential suspect in a criminal investigation might allow them to evade custody, destroy evidence or disrupt an investigation.

If the patient is not told before the disclosure takes place, you should record in writing the reasons why it was not reasonably practical to do so. That record should be written as soon as possible to be contemporaneous and kept thereafter in a safe and secure place.

Additional Information:


Other healthcare regulators guidance regarding confidentiality:


*Confidentiality: NHS Code of Practice Supplementary Guidance: Public Interest Disclosures*, Department of Health, November 2010, Chiropractors have a
professional and ethical responsibility to ensure the safety and wellbeing of their patients.

The professional relationship between a chiropractor and a patient is dependent upon confidence and trust. It is your duty to uphold that trust and confidence. A patient must be able to trust that their chiropractor will provide the best possible care and act in their best interests. Patients must feel confident and safe so that they can be treated effectively and participate effectively in their care.


Guidance on Consent

This guidance must be read in conjunction with The Code (2016) prepared by the General Chiropractic Council (GCC), which sets out standards for conduct, performance and ethics for chiropractors to ensure the competent and safe practice of chiropractic.

This guidance is not intended to cover every situation that you may face. However, it does set out broad principles to enable you to think through and act professionally, ensuring patient interest and public protection at all times.

To note: The GCC will review this guidance as necessary and update it as appropriate, and reapply the principles of the Code to any critical changes or new situations that may emerge.

Standards within the Code with reference to consent:

E: Obtain informed consent for all aspects of patient care.

Other Standards in The Code that reinforce and link to the above:

Refer to all Standards of The Code under Principle E: E1 through to E7. Also,

C7 Follow appropriate referral procedures when making a referral or a patient has been referred to you; this must include keeping the healthcare professional making the referral informed. You must obtain consent from the patient to do this.

C8 Ensure that investigations, if undertaken, are in the patient’s best interests and minimise risk to the patient. All investigations must be consented to by the patient. You must record the rationale for, and outcomes of, all investigations. You must adhere to all regulatory standards applicable to an investigation which you perform.

F3 Involve other healthcare professionals in discussions on a patient’s
care, with the patient’s consent, if this means a patient’s health needs will be met more effectively.

H2 Only disclose personal information without patient consent if required by law.

Consent

For the purposes of this guidance consent refers to the acceptance by a patient of a proposed chiropractic intervention after having been informed about the benefits and risks, in a way that they can understand and having the opportunity to discuss this and other factors that the patient may see as relevant to their decision about that intervention.

It is a general legal and ethical principle that valid consent must be obtained (see below about obtaining consent) before starting assessment or care of a patient. The process of seeking consent is a fundamental part of respect for patients’ rights to be involved in decisions about their treatment. A chiropractor who does not obtain valid consent from a patient may be liable both to legal action by the patient and to fitness to practise proceedings by the GCC. It is important to note that a patient has the right to withdraw their consent at any time.

Types of consent

There are two types of consent:

(i) explicit (or ‘express’) consent: when a patient gives you specific permission either in writing or orally to do something. This is only valid consent if the patient knows and understands to what they are consenting;

(ii) implied consent: when a patient indirectly indicates their agreement to undergo a procedure, for example non-verbal actions such as offering their arm in response to a proposal to carry out a blood pressure test. Implied consent amounts to valid consent if the patient knows and understands what they are agreeing to. If you are not sure whether you have valid consent, then you should seek explicit consent before proceeding.

Obtaining consent

For consent to be valid you must ensure that the patient:

(i) is acting voluntarily;

(ii) has sufficient and balanced information to enable them to make an informed decision;

(iii) is capable of using and weighing up the information provided; and

(iv) has the capacity to give consent.
The information you provide to the patient must be clear, accurate and presented in a way that the patient can understand. For example, when giving a patient specific information you must consider how to meet any need for support that arises from any disabilities, literacy or language barriers they may have.

You must not make assumptions about a patient’s level of knowledge nor assume that all patients are able to comprehend information in the same way. You must be sensitive to varying levels of ability to understand and assimilate information. You must give patients the opportunity to ask questions and reflect on their options. Some patients may need more time to absorb the information you are providing and to reflect before making a decision, it is important that you allow the patient time to do this.

Patients must be fully informed about their care. You must not rely on a patient to ask questions about their care, the responsibility to fully inform patients about their care lies with you. When discussing with patients the expected outcomes of their care, chiropractors must fully discuss the risks as well as the benefits and explore with the patient what other factors they may see as relevant to making a decision.

When explaining risks, you must provide the patient with clear, accurate and up-to-date information about the risks of the proposed treatment and the risks of any reasonable alternative options, in a way that the patient can understand. You must discuss risks that occur often, those that are serious even if very unlikely and those that a patient is likely to think are important. You must encourage patients to ask questions, so that you can understand whether they have particular concerns that may influence their decision and you must answer honestly.

**Recording consent**

You must use the patient’s medical records or a consent form to record the key elements of your discussion with the patient. This record should include all of the information you discussed, any specific requests or concerns expressed by the patient, any written, visual, audio information or other support given to the patient, and details of any decisions that were made. The recording of all information discussed applies to new patients and first appointments as a minimum; after such and at each appointment thereafter you are required to update the patient’s record and record all relevant and pertinent information and discussions. You must obtain a patient’s written signature accompanied by the date at the initial appointment before any treatment commences.

A written copy of the patients record of initial discussions, detailing what decisions were made and why should be offered to every patient. Every patient should also be asked if they want an additional copy of this record and details of their treatment sent to their GP and/or other medical carers as appropriate.
Capacity to give consent

For consent to be valid it must be given by a patient who has the capacity to give consent. Capacity refers to the ability of a patient to understand, retain, use or weigh up information that is relevant to his or her health needs and the examination and/or treatment that you are proposing and communicate their wishes.

You must not assume that a patient lacks capacity to make a decision solely because of their age (see below regarding children and young people), disability, appearance, behaviour, medical condition (including mental illness), their beliefs, their apparent inability to communicate, or the fact that they make a decision that you disagree with.

You must only regard a patient as lacking capacity once it is clear that, having been given all appropriate help and support, they cannot understand, retain, use or weigh up the information needed to make a decision or communicate clearly their wishes. Making decisions about treatment and care for patients who lack capacity is governed by law across the UK. The legislation sets out the criteria and procedures to be followed in making decisions when patients lack capacity to make these decisions for themselves.

England and Wales are governed by the Mental Capacity Act 2005, Scotland is governed by the Adults with Incapacity (Scotland) Act 2000 and Northern Ireland is governed by common law which requires that decisions must be made in a patient’s best interests.

If a patient in England and Wales does not have capacity, the Mental Capacity Act 2005 enables someone who is over 18 years of age and authorised to make decisions for them under a Lasting Power of Attorney (LPA). The LPA must hold the explicit power to make medical/care decisions. Alternatively, someone who has authority to make treatment decisions for that person as a court appointed deputy can give consent. In Scotland the Adults with Incapacity (Scotland) Act 2000 enables someone to hold Power of Attorney and in Northern Ireland it is also known as Power of Attorney.

You must take account of the advice on assessing capacity in the Codes of Practice that accompany the Mental Capacity Act 2005¹, and the Adults with Incapacity (Scotland) Act 2000².

The decision or action taken on behalf of the patient who lacks capacity must be in their best interests.

You must record in the patient notes your reasons for deciding that:

(i) the treatment is in the patient’s best interests;
(ii) the patient lacks capacity.

Ensuring that consent is voluntary

You must ensure that the consent of a patient is given voluntarily and not under any form of pressure or undue influence. It is your duty to ensure that a patient has all the necessary information and support they need in order to give their consent.

Patients may be put under pressure by employers, insurers, relatives or others, to accept a particular investigation or treatment. You should be aware of this and of other situations in which patients may be vulnerable. Such situations may be, for example, if they are resident in a care home, subject to mental health legislation, detained by the police or immigration services, or in prison.

You should do your best to make sure that such patients have considered the available options and reached their own decision. They have a right to refuse treatment, and you should make sure that they know this and are able to refuse if they so wish.

If you have doubts about whether a patient has given valid consent to a treatment, you must consider whether they have been given the information and support that they need and want and how well they understand the details and implications of what treatment is proposed.

Discussing treatment options and continuing treatment

The exchange of information between chiropractor and patient is central to good practice. Good communication is based on listening, you must share with your patients’ accurate, clear and relevant information to enable them to make informed decisions about their treatment options but it is also extremely important that you listen well to the patient and explore their perspectives.

You must take into consideration a patient’s capacity to understand and obtain and record consent from a patient prior to starting their treatment and plan of treatment.

You must make sure that patients are kept informed about the progress of their treatment and are able to make decisions at all stages, not just at the initial stage. If treatment is ongoing, you should make sure that there are clear arrangements in place to review decisions with the patient and, if necessary, to make new ones.

You must also ensure the patient continues to consent to treatment when the circumstances of the patients care changes and that the reviewing process involves the patient as much as possible, ensuring the treatment remains correct for the patient’s needs.

Removal of the patient’s clothing
For the purposes of examination and/or treatment, an alteration and/or removal of items of the patient’s clothing may be necessary.

Before doing this, you must always obtain the patients consent prior to any adjustment and/or removal of clothing. You must also ensure you have clearly explained why it is necessary to do so, and that the patient fully understands.

Extra care must be taken if an adjustment or removal of patients clothing is necessary in a sensitive area, for example the lowering of a patient’s underwear or adjustment of a bra strap. Ideally the patient must do this for themselves, but, if they are unable to do so, you must receive the patient’s permission.

You must only remove or alter clothing that is necessary for the treatment. You must also offer a gown to the patient and a suitable and private place for them to change.

**Treatment of children and young people**

You should involve children and young people as much as possible in discussions about their care, even if they are not able to make their own decisions. The capacity to consent depends more on the patient’s maturity and ability to understand and consider the implications of a decision than on their age.

You must always seek parental consent if a child is to be seen without someone else being present, unless the child is legally competent to make their own decisions.

In clinical practice in the UK, patients over the age of 16 years are treated as independent adults and are assumed to have sufficient capacity to decide their own healthcare treatment. They are permitted to give their consent to or to refuse treatment without parental involvement, unless there is significant evidence to suggest otherwise.

In general, patients under the age of 16 are not deemed to be independent adults and consent is required from the parent(s) or guardian(s). However, some recognition has been given to those under 16 years of age who may be mature enough to make competent decisions for themselves. UK law introduced the concept of the ‘Gillick competent’ child, meaning a child who is under sixteen but deemed mature, intelligent and competent enough to understand the nature and implications of a treatment. Such a child can therefore give consent as an independent adult. The law leaves it to you – the healthcare professional – to decide whether the child is ‘Gillick competent.’ It is therefore imperative that you assess maturity and understanding individually.

If you do not believe a patient of 16 or under is competent and does not have the capacity to consent to their treatment, you must gain consent from someone with parental responsibility for that individual and that person must have the capacity to give consent.

To summarise, when assessing a young person’s capacity and competence to make decisions, you must bear in mind that:
(i) a young person under 16 may have capacity to make decisions, depending on their maturity and ability to understand what is involved; and

(ii) a young person at 16 can be presumed to have capacity to make most decisions about their treatment and care.

Essential Reading:


Additional Information:


- Reference guide to consent for examination or treatment, Department of Health England,

Guidance on maintaining Sexual Boundaries

This guidance must be read in conjunction with The Code (2016) prepared by the General Chiropractic Council (GCC), which sets out standards for conduct, performance and ethics for chiropractors to ensure the competent and safe practice of chiropractic.

This guidance is not intended to cover every situation that you may face. However, it does set out broad principles to enable you to think through and act professionally, ensuring patient interest and public protection at all times.

To note: The GCC will review this guidance as necessary and update it as appropriate, and reapply the principles of the Code to any critical changes or new situations that may emerge.

Standards within the Code with reference to sexual boundaries:

D1: You must not abuse the position of trust which you occupy as a professional. You must not cross sexual boundaries.

Other Standards in The Code that reinforce and link to the above:

D Establish and maintain a clear professional relationship with patients

D2 Be professional at all times and ensure you, and any staff you employ, treat all patients with equal respect and dignity.

D3 Explain the reason to the patient if there is a need for the patient to
remove items of clothing for examination; if that needs to happen, you must offer the patient privacy to undress and the use of a gown.

D4 Consider the need, during assessments and care, for another person to be present to act as chaperone; particularly if the assessment or care might be considered intimate or where the patient is a child or a vulnerable adult.

A2 Respect patients’ privacy, dignity and cultural differences.

Chiropractors have a professional and ethical responsibility to ensure the safety and wellbeing of their patients.

The professional relationship between a chiropractor and a patient is dependent upon confidence and trust. It is your duty to uphold that trust and confidence. A patient must be able to trust that their chiropractor will provide the best possible care and act in their best interests. Patients must feel confident and safe so that they can be treated effectively and participate effectively in their care.

You must not display sexualised behaviour towards patients and/or their carers. Doing so can cause significant and enduring harm.

Sexualised behaviour is defined as acts, words or behaviour designed, intended to arouse or gratify sexual impulses or desires.

**Sexual boundary breaches**

A breach of sexual boundaries can seriously damage the reputation of, and confidence in, the chiropractic profession. A chiropractor who displays sexualised behaviour towards a patient undermines the profession, breaches trust, exploits a power imbalance, acts unprofessionally and may additionally, be committing a criminal act and be the subject of fitness to practise proceedings.

The following non-exhaustive list groups the main types of sexual boundary breaches:

(i) Criminal sexual acts as governed by the law in England and Wales\(^1\), Scotland\(^2\), Northern Ireland\(^3\); the Isle of Man\(^4\) and the Channel Islands.

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(ii) sexual relationships;
(iii) other sexually motivated actions which may constitute an assault or sexual assault on patients such as unnecessary physical contact and inappropriate gestures, including unwarranted touching, hugging and kissing;
(iv) other sexually motivated actions towards patients such as sexual humour or sexually inappropriate comments; and
(v) inappropriate sexual remarks or conversations about patients to anyone in or outside of the workplace - including but not restricted to all types of social media.

Acknowledging the power imbalance

It is your responsibility to be aware of the potential for an imbalance of power between you and your patients, and to maintain professional boundaries.

You occupy a position of trust with respect to your patients. An imbalance of power is a feature of the chiropractor/patient relationship, although this may not be explicit. Patients often are or feel vulnerable when they require care. Chiropractors are in a position of power as they have access to the knowledge and any resources that the patient may need.

There are a number of factors within the treatment process which may generate a power imbalance, including, but not limited to:

(i) a patient may have to share personal information;
(ii) it is the chiropractor who influences the level of physical contact;
(iii) it is the chiropractor who influences the number and regularity of treatments; and
(iv) the chiropractor knows what constitutes appropriate professional practice whereas the patient may be in an unfamiliar situation and may not know what is appropriate in terms of physical interaction, treatment or sharing personal information.

Avoiding breaches of sexual boundaries

Chiropractors may find themselves sexually attracted to patients or their carers, or be in a situation where patients or their carers are sexually attracted to them.

It is your responsibility never to act on these feelings in order to prevent any harm that any such actions may cause, and to maintain the integrity of and confidence in the chiropractic profession.
Acknowledging signs of sexual attraction

There are a number of behaviours that may be indicators or interpreted as signs of showing sexualised, and therefore unprofessional, behaviour towards patients or carers.

These include:

(i) revealing intimate personal details about oneself;
(ii) giving or accepting inappropriate or unprofessional social invitations;
(iii) visiting a patient’s home without an appointment;
(iv) meeting a patient outside of normal practice hours when no other staff/patients are present, or arranging appointments outside of the workplace for example at the patients home; and
(v) asking questions that are unintended to be and are not related to the patient’s health.

The above behaviours should be avoided. If a home visit is absolutely necessary for treatment it is important that you are aware of how your actions could be misinterpreted and that you act with the upmost professionalism at all times.

If you are sexually attracted towards a patient

If you are sexually attracted to a patient and are concerned that it may affect your professional relationship with them, you should ask for help and advice from a colleague or appropriate professional body in order to decide on the most professional course of action to take.

If, having sought advice, you do not believe you can remain objective and professional, you must:

(i) find an alternative chiropractor for the patient;
(ii) ensure a proper transfer to another chiropractor takes place; and
(iii) transfer care in a way that does not make the patient feel that they have done anything wrong.

You must end a professional relationship with a patient if you pursue a personal relationship with them.

If a patient displays sexual attraction towards you

If a patient displays sexualised behaviour towards you, it is strongly recommended that you seek advice from a colleague or an appropriate professional body. An appropriate course of action might be to discuss the patient’s feelings and attraction in a constructive manner in order to try to re-
establish a professional relationship. It is strongly recommended that a colleague be present when this discussion takes place.

If this is not possible, the patient should be transferred to an alternative chiropractor colleague for future treatment. Again advice should be sought from a colleague or a professional body.

**Sexual relationships with former patients or their carers**

Sexual relationships with any former patient or carer are often inappropriate however long ago the professional relationship ended. This is because the sexual relationship may be influenced by the previous professional relationship, which will have involved an imbalance of power.

If you think that a relationship with a former patient might develop, you must seriously consider the possible future harm and potential impact on your own professional status. You must use your professional judgment and give careful consideration to the following:

(i) how long the professional relationship lasted and how recently it ended;
(ii) whether the former patient was particularly vulnerable at the time of the professional relationship, and whether they might still be considered vulnerable;
(iii) the nature of the previous professional relationship and whether it involved a significant imbalance of power;
(iv) whether an exploitation of power, trust or knowledge obtained whilst there was a professional relationship has influenced the development or progression of a sexual relationship; and
(v) whether you are, or in future are likely to be, treating other members of the former patient’s or carer’s family.

If you are unsure whether you are, or could be seen to be, abusing your professional position, you should always seek advice from an appropriate professional body.

However consensual a relationship appears to be, if a complaint is made by the patient, or a disclosure of the relationship is made by anyone, the onus will always be on you to show that you have acted professionally by giving serious consideration to the points above in relation to the circumstances in question, and by seeking appropriate advice.

**Disclosure of sexual boundary breaches**

If you become aware that another professional has breached sexual boundaries
with a patient or carer, you have an ethical and professional duty to take action. Failure to take steps to prevent harm to a patient or carer may amount to misconduct by you and lead to fitness to practise action being taken against you.

You must:

(i) alert the police, the GCC, and the chiropractor’s employer where you have reason to believe that a sexual assault, rape or other potentially criminal act has occurred;
(ii) report to the chiropractor’s employer and/or the GCC in all other circumstances where you have reason to believe that there has been an instance of sexualised behaviour towards a patient.

Patient confidentiality should be respected wherever possible when reporting concerns and, wherever practical, you should seek the patient’s consent to disclose any information (see separate Consent guidance and Confidentiality guidance).

Nevertheless, the safety of patients must always come first and must take precedence over maintaining confidentiality. If you are satisfied that it is necessary to identify the patient, and consent by the patient to do so is refused, you can still disclose the information if it is in the best interests and safety of the patient. You must inform the patient of your intention to disclose. If you are in doubt advice should be sought from a colleague or professional body.

Essential reading:


Additional information:


<table>
<thead>
<tr>
<th>Strategic Risk description</th>
<th>Risk Event</th>
<th>Inherent Score</th>
<th>Controls and monitoring procedures currently in operation</th>
<th>Further actions planned to reduce the risk to a tolerable level and progress to date</th>
<th>Residual score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to protect the public</td>
<td>The failure to introduce a system of assuring the continued fitness to practice of chiropractors</td>
<td>3 5 15</td>
<td>Council agreed in 2014 that the Education Committee would lead in carrying out a review of the CPD scheme in light of enhancements made by other regulators and to provide greater assurance of registrants continuing fitness to practice. The Education Committee reported upon progress in March 2015 and agreed a work programme to develop a scheme for Continuing Fitness to Practice.</td>
<td>PSA are kept up to date with progress in this area and regular meetings are held with other regulators in order to learn from them. The Education Committee discusses progress at each of its meetings and will update Council in June 2016.</td>
<td>2 4 8</td>
</tr>
<tr>
<td>Failure to maintain confidence of stakeholders</td>
<td>The recent governance issues have damaged the reputation of the GCC with its stakeholders and in particular the Professional Standards Authority, Department of Health and the Privy Council. Council acted quickly after the emergency meeting of this Committee in December 2015 in instructing a full governance review with defined terms of reference. The results of this governance review were presented to Council on 22 January 2016. An action plan has been considered by the audit committee. It is expected that a number of actions will have been completed or instructed by the time that the Council meets in March 2016.</td>
<td>4 4 16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to meet the required standard in all areas of the PSA performance report.</td>
<td>The PSA performance report for 2014/15 identified standards which had not been met for the period. These followed a self reporting by the GCC after receipt of an external audit of case files. The committee noted the concerns in 2014 and agreed an action plan. The committee has reviewed the plan which incorporated enhanced monitoring and an increase in the skill levels in the FIP team. The GCC have already made changes to the FIP manual and associated monitoring processes have been revised to ensure compliance. The GCC have also enhanced the staffing structure to bring in additional skills and experience to implement the recommendations of the GCC audit in February 2014. The Committee agreed a series of quarterly audits and the first of these took place in February 2015. The Committee has now received three audits all which show a major improvement across all areas of case management. The recent audit which began on February 8th has concluded with additional positive outcomes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of information security breaches of data</td>
<td>The organization has looked very carefully at internal security procedures for data and classification of data. Furthermore a detailed note on data protection procedures has now been implemented within the office procedure manual. All members of staff have now received further training on their responsibilities in relation to both the Data Protection Act (DPA) and Freedom of information Act in September 2014 and the FIP team has attended a seminar by a firm of solicitors.</td>
<td>4 4 16</td>
<td>Enhanced training was delivered in September 2014 for all members of staff. The GCC had also increased the skills and experience of the FIP team by appointing two FIP lawyer advocates and as a result we expect that the level of breaches will reduce. Further training for the FIP team and any new members of staff will take place in March 2016. We will be carrying out an information governance audit in 2016.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to manage changes in financial activity leading to capital withdrawals from the investment portfolio.</td>
<td>Council agrees the budget each year and monitors financial performance by way of regular reports to Council. Council has agreed an investment strategy and the investment manager reports on a monthly basis and also attends Council meetings, as requested.</td>
<td>3 3 9</td>
<td>Council has agreed a budget with a deficit of £84K. This will not require a drawdown from the investment portfolio. The current management accounts for the end of December 2015 do not indicate any major problem that would affect this position.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure of Council to work effectively and make policy decisions in the public interest</td>
<td>Council member appraisals have taken place recently. Recent governance issues do relate to the whether decisions were made effectively and appropriately. The governance review has highlighted concerns in relation to confidentiality, individual member responsibility, and collective Council member responsibility along with concerns about governance documentation.</td>
<td>4 4 16</td>
<td>Training on the recommended areas is to be provided on March 9th. The changes to the governance documentation will begin in the next few weeks with a revised governance manual coming to the Audit Committee in May and then to Council in June. If required, a further training day will be arranged for September.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Residual scores: 1 = Low, 2 = Medium, 3 = High, 4 = Very High, 5 = Critical
To: The Council, General Chiropractic Council  
From: Paul Ghuman, Director of Resources and Regulation  
Subject: Performance Report  
Date: 10 March 2016

1. Purpose

The purpose of this paper is to present to Council the Performance Report covering the period up to the end of December 2015.

2. Executive Summary

In respect of KPI’s, there remained one KPI which showed an adverse variance almost throughout 2015 which was listing cases referred to the Professional Conduct Committee (PCC) within 9 months. It is expected that this will not be the case in 2016. The indicators that should lead to this improvement are that following increased hearing days over recent years, the pipeline of PCC cases has steadily reduced. At the start of 2015, there were 22 cases to be determined which reduced to 9 by the year-end. This is a significant reduction of almost 60%. Also, the large bulge of old PCC cases has been determined and this will allow the team to deal with current cases only and to seek that this KPI is met in 2016.

Business plan activities scheduled for 2015 were ambitious, but have been achieved to a large degree by the end of the year. There were some knock-on effects of the Code of Practice being approved later in the year than originally anticipated. These will mean that some of this work such as Guidance and Review of Criteria for recognition of degrees will be completed in 2016.

The financial summary shows the position as at the end of December 2015 as being a surplus of just under £7k which is a much improved situation, as we were forecasting a deficit for the year of £39K.

The year end income figure is £2,443K (2014: £2,369K) which is an increase of 3% from 2014.

The deficit against budget is largely due to investment income where there was a return of £127K against a forecast of £168K.

The year end expenditure figure is £2,437K (2014: £2,475K) which is a reduction of 1%. The main costs around FtP (£591K) are also slightly lower than that forecast (£617K).
2. Summary

Key Performance indicators

The only indicator that is showing a red status (where we are not meeting our target), is “listing PCC hearings within 9 months of referral of case from the IC”. The current position is that 50% of cases have been listed within nine months in 2015.

There have been improvements throughout the year in determining old cases, and this is exemplified by the pipeline of cases reducing from 22 to 9 at the end of the year. This is a reduction of over 60%.

Business Plan

Most activities due to be delivered by the end of Quarter 4 have progressed as planned. Key activities which have been delivered during the year are a reduction in hearing room costs, approving of the Code of Practise and Standard of Proficiency, the appointment of legally Qualified Chairs of the Fitness to Practise Committees and improved processes for equality impact assessments.

We have started work in relation to producing guidance to support the approval of the Code of Practice. That work will continue into 2016. As a result of the late approval of the Code, work in revising the Degree Recognition Criteria will now commence and be developed in 2016.

Research into student preparedness to practice will now commence in 2016.

Financial Summary

Income

At the end of December, the income for the year was £2,443k and the expected income was £2,494k. This leads to a reduction of £51k on what we expected to receive. This is primarily as a result of investment income showing a difference of £41k against that forecast. The investment income forecast is much closer to a 3% return rather than the expected 4%.

The overall difference on registration income is £10k as a result of a larger number of overseas students not registering with the GCC.

Expenditure

At the end of December we have spent £2,437k. We expected to spend £2,534k. Thus, we have spent £97k less than forecast.

There is a positive differences on a number of areas including FtP costs where we have spent £26k less than expected at the year end. The costs in relation to FtP can be extremely variable and have been closely monitored throughout the year.

There are also positive differences on accommodation, IT costs and office costs of £43k in total.

The surplus for the year is £6k, in comparison to a forecast deficit of £39k, leading to a positive difference of £45k.
The grant balance from the Department of Health for work on Continuing Fitness to Practice was £70k at the end of the year.

The figures do not include fees and costs in relation to the Test of Competence. The net position is a deficit of £7K.

It should be noted that these figures exclude year end journals.

**Portfolio**

Stock markets have been in some turmoil in recent months and the portfolio valuation at 31 December was £4,238k.

**3. Action required**

Council is asked to note the Performance Report.

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Paul Ghuman  
Email: p.ghuman@gcc-uk.org  
Telephone: 020 7713 5155
Performance Management and monitoring of the operational action plan

December 2015
## Overview

### Major Events

**Chair of Council**
The Chair of Council resigned with effect from 1\textsuperscript{st} January 2016. An appointment process will be put in place early in 2016.

The Council nominated Roger Dunshea as the Deputy Chair of Council on 22\textsuperscript{nd} December 2015.

**PSA**
George Jenkins OBE has been appointed by the Privy Council as Chair of the Professional Standards Authority from January 2016. He succeeds Baroness Pitkeathley.

**Healthcare Bill**
Both the Chair and the Chief Executive attended a meeting with Ben Gummer, Parliamentary Under Secretary of State for Quality at Department of Health. Furthermore, there was a meeting with Department of Health officials, which the Chief Executive attended.

During 2016, DH will work with regulators to develop concrete proposals, so that they will be able to submit a Bill for pre-legislative scrutiny during 2017/18. The expectation is that the legislation will receive Royal Assent before the end of this Parliament.

Also, the Minister wants to challenge regulators to try and reduce the regulatory burden on registrants by cutting registration fees or at least not increasing them. The DH is concerned about the rising costs to registrants in some Regulators.

The minister was also supportive of giving regulators significant autonomy in the Bill to allow them to adapt more readily to changing environments.

### Business Plan delivery

Council agreed that the GCC’s Executive should report on any activity that was not proceeding as planned. These are highlighted on page 6.

### Key Performance Indicators

We are not hitting our target to list 90% (actual 50%) of PCC hearings within nine months of referral. This is explained on Page 5.

### Financial

The net difference on retention income is £10k at the end of December 2015.

The investment portfolio income is £127K. This is £41K less than expected. The target given to the investment manager is 4%. The balance will be made up from capital as agreed in the investment strategy. The profit on our investment portfolio is £237k. There remains a great deal of turmoil in the financial markets on a number of fronts. Cazenove presented the portfolio performance to Council in December 2015.

Income at the year end is below that planned by £51K.

Expenditure at the year end is below that planned by £97K.

The overall surplus before taxation and year end journals is £6K.

The financial summary is on page 3 and 4.
# December 2015 Performance report

## Financial Summary – As at 31st December 2015

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Difference</th>
<th>2015 Budget</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Registration</td>
<td>125,050</td>
<td>137,250</td>
<td>-12,200</td>
<td>137,250</td>
<td>1</td>
</tr>
<tr>
<td>Non practising to practising</td>
<td>13,600</td>
<td>8,000</td>
<td>5,600</td>
<td>8,000</td>
<td></td>
</tr>
<tr>
<td>Restoration</td>
<td>19,150</td>
<td>7,500</td>
<td>11,650</td>
<td>7,500</td>
<td></td>
</tr>
<tr>
<td>Retention - Practising</td>
<td>2,128,800</td>
<td>2,143,200</td>
<td>-14,400</td>
<td>2,143,200</td>
<td></td>
</tr>
<tr>
<td>Retention - Non Practising</td>
<td>30,000</td>
<td>30,300</td>
<td>-300</td>
<td>30,300</td>
<td></td>
</tr>
<tr>
<td>Investment Income</td>
<td>126,779</td>
<td>168,000</td>
<td>-41,221</td>
<td>168,000</td>
<td>2</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td>2,443,379</td>
<td>2,494,250</td>
<td>-50,871</td>
<td>2,494,250</td>
<td></td>
</tr>
</tbody>
</table>

## Expenditure

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Budget</th>
<th>Difference</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Costs</td>
<td>1,043,816</td>
<td>1,044,114</td>
<td>298</td>
<td>1044,114</td>
</tr>
<tr>
<td>IT costs</td>
<td>58,018</td>
<td>80,000</td>
<td>21,982</td>
<td>80,000</td>
</tr>
<tr>
<td>Office Costs</td>
<td>148,603</td>
<td>168,500</td>
<td>19,897</td>
<td>168,500</td>
</tr>
<tr>
<td>Accommodation Costs</td>
<td>224,921</td>
<td>228,200</td>
<td>3,279</td>
<td>228,200</td>
</tr>
<tr>
<td>Finance costs</td>
<td>19,039</td>
<td>21,465</td>
<td>2,426</td>
<td>21,465</td>
</tr>
<tr>
<td>Professional fees</td>
<td>133,203</td>
<td>157,500</td>
<td>24,297</td>
<td>157,500</td>
</tr>
<tr>
<td>Council costs</td>
<td>177,099</td>
<td>166,800</td>
<td>-10,299</td>
<td>166,800</td>
</tr>
<tr>
<td>Communication</td>
<td>8,927</td>
<td>18,000</td>
<td>9,073</td>
<td>18,000</td>
</tr>
<tr>
<td>Registrations</td>
<td>15,802</td>
<td>7,000</td>
<td>-8,802</td>
<td>7,000</td>
</tr>
<tr>
<td>Education</td>
<td>16,758</td>
<td>25,130</td>
<td>8,372</td>
<td>25,130</td>
</tr>
<tr>
<td>FtP</td>
<td>590,847</td>
<td>617,000</td>
<td>26,153</td>
<td>617,000</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td>2,437,033</td>
<td>2,533,709</td>
<td>96,676</td>
<td>2,533,709</td>
</tr>
</tbody>
</table>

## Surplus / (Deficit)

- Surplus / (Deficit)  
  - Surplus / (Deficit):  
    - **6,346**  
    - **-39,459**  
    - **45,805**  
    - **-39,459**

### Grant Funding - Earmarked for Revalidation

<table>
<thead>
<tr>
<th>Category</th>
<th>Balance b/f</th>
<th>Income</th>
<th>Expenditure</th>
<th>Balance c/f</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grant Funding - Earmarked for Revalidation</td>
<td>76,818</td>
<td>0</td>
<td>7,120</td>
<td>69,698</td>
</tr>
</tbody>
</table>
Note 1:
Initial registration fees were £12k lower than expected. This is as a result of higher numbers of registrants not registering in the UK following graduation. Forward budgets and forecasts have been adjusted. Overall registration income was £10K below than planned.

Note 2:
The income performance on the investment portfolio for the year is £127K which is just above a 3% income return. The balance up to the 4% budget will be made up from capital.

Note 3:
The costs for IT remained lower than planned with a final spend of £58K. We were unable to agree costs for the website development and this work will now take place in 2016.

Note 4
Professional fees are lower than expected as a result of the Degree Recognition Criteria project start date being delayed as the Code was only approved in June 2015. The large proportion of this work will now fall in to 2016 and possibly finalise in 2017. Legal fees were greater in the year than originally forecast.

Note 5
Council costs were higher that expected primarily as a result of increased expenses which includes the dinner at the Athenaeum and speaker fees at certain events.

Note 6
FtP cost remain difficult to predict but the year-end position is that costs were contained within budget for the year.

Portfolio Valuation
The portfolio valuation was £4,237,882 as at 31 December 2015.
### Key Performance Indicators

<table>
<thead>
<tr>
<th>Fitness to Practise</th>
<th>Status</th>
<th>Exception Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>To list 90% of PCC hearings within nine months of referral</td>
<td></td>
<td><strong>Actual rate</strong>&lt;br&gt;50% of cases listed in 2015 were within nine months of referral. This percentage dropped in the last quarter as the last group of old cases were determined. <strong>Reason</strong>&lt;br&gt;The reason for this failure to meet our target is because of the increased number of referrals to the PCC following determination of the backlog of cases by the IC at the end of 2012 and during 2013. There have, of course, been the referrals from normal complaints in the following years as well. <strong>Action</strong>&lt;br&gt;To cope with this the number of hearing days allocated in 2016 remains high but crucially the pipeline of PCC cases has reduced. This will now allow the FtP system to investigate relatively recent cases rather than historic ones.</td>
</tr>
</tbody>
</table>

During 2015, the GCC had received 52 complaints, of which 50% have been determined in the year.

During 2014, we had received 64 complaints and all of these have been determined by the Investigating Committee.
**Operational plan progress – by strategic aim and activity**

The majority of activities due for completion in 2015 have been achieved including:

- agreeing the Code of Practice and Standard of Proficiency
- appointing legal qualified chairs for the FtP Committees
- increasing pool of experts
- developing equality and diversity in all functional areas
- Review of datasets of all regulators and participating in shaping the final PSA dataset for all regulators
- Extending use of social media, introducing webinars and regular publishing of the GCC newsletter
- Securing cost savings in FTP hearing accommodation

There are a few activities which were due to start in Q4 but were planned to complete in 2016 and these are currently in progress.

Other activities which will now be carried out in 2016 and have been included in the Business Plan for 2016 are:

- Review of Criteria for recognition of Degrees and associated activities
- Guidance to support the Code of Practice (initial work has started in 2015 and will complete in 2016)
- Research into Student Fitness to Practise and Pre-registrant professionalism
GCC Non-Executive Director Remuneration Review

1. Introduction and scope of this paper
The purpose of this paper is to provide an independent evaluation of the remuneration of the GCC non-executive (NED) or honoraria roles of the General Chiropractic Council. These roles are:

- **Chair of Council** (1) [https://www.gcc-uk.org/about-us/council/council-meetings.aspx](https://www.gcc-uk.org/about-us/council/council-meetings.aspx)
- **Council Member** (2) [https://www.gcc-uk.org/about-us/council/council-meetings.aspx](https://www.gcc-uk.org/about-us/council/council-meetings.aspx)
- **Committee Chair** (3) of Non-statutory committees & conduct committee
- **Committee Member** (4) of Non-statutory committees & conduct committee

This paper aims to establish an evidence based assessment of the roles relative to comparable roles in the external market, to the extent that they exist. It has been prepared for David Howell, CEO who holds the most senior executive role at GCC in order to minimise conflict of interest risks. The GCC remuneration or honoraria of non-executive roles has been compared using the role purpose and responsibilities of the non-executive roles provided by GCC.

2. Comparisons with other organisations:
- Regulatory body data is included on Page 2 (see 5) however the time commitment information for some roles is not available which reduces its application for comparison purposes. Appendix 1 lists organisations that are Non-Departmental Public Bodies (NDPBs), Housing Associations & NHS Trusts obtained from public domain sources.
- For context it is difficult to obtain a large bank of comparable data for GCC as organisations are structured differently and there are large size variations i.e. GMC or NMC vs. GCC. However there are variations in terms of remuneration and time commitments as per Appendix 1.

3. Factors impacting benchmarking
- Obtaining quality benchmark data for NED/honoraria roles is difficult to achieve since good quality participation salary surveys do not currently exist for such roles. This is not a surprise as the range of variables including job size and time commitments are not always clearly defined.
- The lack of good quality benchmark data may also be linked to the view held that £remuneration is not typically a primary driver for skilled professionals choosing to carry out such roles.

4. GCC Non-Executive Roles – time commitment and daily rate or assumed daily rate

<table>
<thead>
<tr>
<th>NED role</th>
<th>Any role specifics</th>
<th>2015-16 time commitment</th>
<th>2015-16 Remuneration</th>
<th>Actual or assumed £rate *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair of Council</td>
<td>This is a statutory role</td>
<td>46 days max per year (was 78)</td>
<td>£23,440 per year</td>
<td>£509.56 per day*</td>
</tr>
<tr>
<td>Council Member</td>
<td>This is a statutory role</td>
<td>15 days per year (was 22)</td>
<td>£6,650 per year</td>
<td>£443.33 per day**</td>
</tr>
<tr>
<td>Committee Chair</td>
<td>Rate higher for legally qualified</td>
<td>Varies/ per diem rate</td>
<td>£500 per diem</td>
<td>£500 per day</td>
</tr>
<tr>
<td>Committee Chair</td>
<td>Non-statutory or conduct cm’tree</td>
<td>Varies/ per diem rate</td>
<td>£300 per diem</td>
<td>£300 per day</td>
</tr>
<tr>
<td>Committee Member</td>
<td>Non-statutory or conduct cm’tree</td>
<td>Varies/ per diem rate</td>
<td>£300 per diem</td>
<td>£300 per day</td>
</tr>
</tbody>
</table>
(*) The per diem remuneration of the Council Chair is now based on the 46 days p.a. commitment estimate provided by Paul Ghuman on 28th Jan 2016. This is now (post 28 Jan 2016 update) in line with the size of GCC though it exceeds that of the General Pharmaceutical Council at 40 days p.a.

(**) the per diem remuneration of the Council Member role has been updated to reflect 46 days p.a.

- **Chair of Council** (1) 2015 fees @ £23,440 p.a. for 46 days p.a. or £509.56 per day.

- **Council Member** (2) 2015 fees @ £6,650 p.a. for 15 days p.a. with 4 meetings p.a. per schedule [https://www.gcc-uk.org/about-us/council/council-meetings.aspx](https://www.gcc-uk.org/about-us/council/council-meetings.aspx) or £443.33 per day.

- **Not-statutory committees & conduct committee**: Chair role 2015 fees @ £300 per day (3b) with £500 per day for Legally Qualified Chairs. (3a). Member roles (4) @ £300 per day.

5. **Regulatory body benchmark data for Chair of Council, Council members & FtP panellists**

<table>
<thead>
<tr>
<th>Regulatory body</th>
<th>Chair rate p.a. or Assumed daily rate</th>
<th>Council Member/Assumed daily rate</th>
<th>Conduct Committee Actual daily rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>GMC (Medical)</td>
<td>£110,000</td>
<td>£18,000 or £500 pd (36 days pa)</td>
<td>£310 pd</td>
</tr>
<tr>
<td>NMC (Nursing &amp; Midwifery)</td>
<td>£48,000 or £480 pd (100 days)</td>
<td>£12,000 or £400 pd (30 days)</td>
<td>£310 pd</td>
</tr>
<tr>
<td>HPC (Health &amp; Care)</td>
<td>Day rate + allowance. £65-70k for 2015</td>
<td>£320 pd</td>
<td>Member: £190 Chair: £320</td>
</tr>
<tr>
<td>GOC (Optical)</td>
<td>£40,000</td>
<td>£13,000</td>
<td>Member: £300 Chair: £330</td>
</tr>
<tr>
<td>GDC (Dental)</td>
<td>£55,000 or £550 pd (100 days)</td>
<td>£15,000 or £750 pd (15-20 days p.a.)</td>
<td>£353 pd panellists &amp; Chair</td>
</tr>
<tr>
<td>GPhC (Pharmaceuticals)</td>
<td>£48,000 or £960 pd (50 days)</td>
<td>£12,000 or £300 pd (40 days)</td>
<td>Member: £300 Chair: £500 Legally Qual.</td>
</tr>
<tr>
<td>PSA (Prof. Standards)</td>
<td>£33,688</td>
<td>£7,881</td>
<td>N/A</td>
</tr>
<tr>
<td>GCC (2015)</td>
<td>£23,440</td>
<td>£6,650</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Provided by GCC in 9th Nov 2015 remuneration committee, originally provided by S Doyle.

6. **Commentary and conclusions**

- Remuneration varies widely for the GCC Chair of Council and Council member roles compared to the external market. However the Council Chair rate at £509.56 is based on 46-days p.a. which is representative for the size and scope of GCC. Note: This has been updated based on the new information provided by Paul Ghuman on 28th Jan 2016.

- For the Council member rate at £443 p.d. this is comparable or higher than for other regulatory bodies and there is no supporting case to review this remuneration for 2016.

- The rates of committee and Chair roles at £300 pd is broadly in line with remuneration offered by other regulatory bodies. However this increases by £200 pd for legally qualified chairs. The introduction of legally qualified chairs was agreed by Council. More information is required on this approach to make an informed observation on this practice. In summary no upward change is required for these roles.
### 7. Summary of recommendations

<table>
<thead>
<tr>
<th>NED role</th>
<th>GCC 2015 Remuneration</th>
<th>2015 actual or assumed £rate *</th>
<th>GCC 2016 recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair of Council (1)</td>
<td>£23,440 per year</td>
<td>£509.56 per day*</td>
<td>No change based on 46 days for the requirements of the role</td>
</tr>
<tr>
<td>Council Member (2)</td>
<td>£6,650 per year</td>
<td>£443.33 per day**</td>
<td>No change is required</td>
</tr>
<tr>
<td>Committee Chair – Legally Qualified</td>
<td>£500 per diem</td>
<td>£500 per day</td>
<td>Clarify legal qualification basis though no upward change required</td>
</tr>
<tr>
<td>Committee Chair – NOT Legally Qualified</td>
<td>£300 per diem</td>
<td>£300 per day</td>
<td>No change required</td>
</tr>
<tr>
<td>Committee Member (4)</td>
<td>£300 per diem</td>
<td>£300 per day</td>
<td>No change required</td>
</tr>
</tbody>
</table>

Prepared by Sylvia Doyle, Independent member of the GCC Remuneration Committee

### Appendix 1

**Benchmark data of NDPBs; Housing Associations & NHS Trust organisations - Nov 2014**

<table>
<thead>
<tr>
<th>NED or Chair role</th>
<th>Remuneration £pa</th>
<th>Time Commitment</th>
<th>Assumed daily rate £</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Exec Director</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member Social Security Advisory Committee</td>
<td>£9,245</td>
<td>36 days pa</td>
<td>£257 per day</td>
</tr>
<tr>
<td>Forestry Commission</td>
<td>£11,111</td>
<td>24 days pa</td>
<td>£463 per day</td>
</tr>
<tr>
<td>Remploy Ltd</td>
<td>£7,688</td>
<td>30 days pa</td>
<td>£256 per day</td>
</tr>
<tr>
<td>Care Quality Commission</td>
<td>£7,883</td>
<td>30 days pa</td>
<td>£263 per day</td>
</tr>
<tr>
<td>Committee on Standards in Public Life</td>
<td>£5,760</td>
<td>24 days pa</td>
<td>£240 per day</td>
</tr>
<tr>
<td>Driver &amp; Vehicle Standards Agency</td>
<td>£15,000</td>
<td>36 days pa</td>
<td>£416 per day</td>
</tr>
<tr>
<td>Legal Services Ombudsman</td>
<td>£10,000</td>
<td>20 days pa</td>
<td>£500 per day</td>
</tr>
<tr>
<td>Bank of England</td>
<td>£15,000</td>
<td>36 days pa</td>
<td>£417 per day</td>
</tr>
<tr>
<td>Ministry of Defence, Equipment &amp; Support</td>
<td>£15,000</td>
<td>36 days pa</td>
<td>£417 per day</td>
</tr>
<tr>
<td>Architects Registration Board</td>
<td>£2,500</td>
<td>5 – 10 days pa</td>
<td>£250 per day</td>
</tr>
<tr>
<td>£17m turnover HA</td>
<td>£3,000</td>
<td>12 days pa</td>
<td>£250 per day</td>
</tr>
<tr>
<td>£45m turnover HA</td>
<td>£6,000</td>
<td>12 days pa</td>
<td>£500 per day</td>
</tr>
<tr>
<td>Sussex NHS Community Care Trust</td>
<td>£6,157</td>
<td>30 days pa</td>
<td>£205 per day</td>
</tr>
<tr>
<td>West Hertfordshire NHS Trust</td>
<td>£14,000</td>
<td>48 days pa</td>
<td>£292 per day</td>
</tr>
<tr>
<td>Sheffield Foundation NHS Trust</td>
<td>£15,500</td>
<td>48 days pa</td>
<td>£322 per day</td>
</tr>
<tr>
<td><strong>Chair</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Pension Board</td>
<td>£13,137</td>
<td>36 days pa</td>
<td>£365 per day</td>
</tr>
<tr>
<td>Review Body on Senior Salaries</td>
<td>£10,500</td>
<td>30 days pa</td>
<td>£350 per day</td>
</tr>
<tr>
<td>Pensions Advisory Service</td>
<td>£30,500</td>
<td>60 days pa</td>
<td>£508 per day</td>
</tr>
<tr>
<td>Ombudsman Services</td>
<td>£46,000</td>
<td>50 days pa</td>
<td>£920 per day</td>
</tr>
<tr>
<td>Architects Registration Board</td>
<td>£10,000</td>
<td>35 – 40 days pa</td>
<td>£250 per day</td>
</tr>
<tr>
<td>Civil Aviation Authority Consumer Panel</td>
<td>£20,000</td>
<td>50 days pa</td>
<td>£400 per day</td>
</tr>
<tr>
<td>South Devon Health Care Trust</td>
<td>£43,000</td>
<td>130 days pa</td>
<td>£331 per day</td>
</tr>
<tr>
<td>£17m turnover HA</td>
<td>£8,000</td>
<td>36 days pa</td>
<td>£222 per day</td>
</tr>
<tr>
<td>£45m turnover HA</td>
<td>£15,000</td>
<td>36 days pa</td>
<td>£417 per day</td>
</tr>
</tbody>
</table>
## Council work plan for 2016

<table>
<thead>
<tr>
<th>Date</th>
<th>10th March</th>
<th>16th June</th>
<th>29th September</th>
<th>5th December</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Update report from the Audit Committee</strong></td>
<td>Update report from the Audit Committee</td>
<td>Review of retention fees</td>
<td>Update report from the Audit Committee</td>
<td></td>
</tr>
<tr>
<td><strong>Review of Strategic Risk Register</strong></td>
<td>Strategic Risk Register - any items scoring over 15</td>
<td>Review of Strategic Risk Register</td>
<td>Strategic Risk Register - any items scoring over 15</td>
<td></td>
</tr>
<tr>
<td><strong>Guidance notes</strong></td>
<td>Education Committee update incl CPD review update and TOC Year 1 Evaluation</td>
<td>Review Strategic Statement</td>
<td>Financial Strategy Review incl Investment Strategy</td>
<td></td>
</tr>
<tr>
<td><strong>Reserves</strong></td>
<td>Management letter and letter of representation</td>
<td>Draft Business Plan and budget</td>
<td>Remuneration Committee's report</td>
<td></td>
</tr>
<tr>
<td><strong>Use of the title 'Dr'</strong></td>
<td>Financial Statements</td>
<td>Draft business plan and budget</td>
<td>Education Ctte annual report</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual report and accounts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Poss Education Standards</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ITEMS TO NOTE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Performance Report emailed monthly (last week of each month)

<table>
<thead>
<tr>
<th>Date</th>
<th>March</th>
<th>June</th>
<th>September</th>
<th>December</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minutes from Audit Ctte</td>
<td>Minutes from Audit Ctte</td>
<td>Minutes from Education Ctte</td>
<td>Minutes from REmCo</td>
<td></td>
</tr>
<tr>
<td>Minutes from Education Ctte</td>
<td>Minutes from Education Ctte</td>
<td>Council dates for 2017</td>
<td>Minutes from Education Ctte</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Minutes from Audit Ctte</td>
<td></td>
</tr>
</tbody>
</table>