## 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. Items marked with an asterisk are supported by a Paper or other documents. All other items are dealt with orally.

<table>
<thead>
<tr>
<th>Item</th>
<th>Action</th>
<th>Timing</th>
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<tbody>
<tr>
<td>Apologies and declarations of interest</td>
<td>To note</td>
<td>11.30-11.35</td>
</tr>
<tr>
<td>C-310315-1 Draft minutes of meeting of 1\textsuperscript{st} December 2014</td>
<td>To note</td>
<td>11.35-11.40</td>
</tr>
<tr>
<td>C-310315-2 Matters arising and action log</td>
<td>To approve</td>
<td>11.40-11.50</td>
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</tbody>
</table>
| C-310315-3 Chair’s Report  
- Board effectiveness and appraisals  
- PSA seminar | to note | 11.50-12.00 |
| C-310315-4 Chief Executive’s Report  
- Report on attendance at conferences  
- Update on Welsh language scheme  
- ICRC meeting at WFC Congress in Athens  
- Non-practising register  
- Update on research proposals*  
- Equality and Diversity  
- Update on Department of Health meeting  
- Advertising*  
- Letter to registrants re: Spencer case*  
- Letter re: accreditation*  
- Use of the courtesy title Doctor/ Dr* | to note | 12.00-12.45 |
| C-310315-5 CPD scheme and continuing fitness to practise* | To decide | 12.45-13.10 |
| Lunch | | 13.10-13.40 |
| C-310315-6 Review of the Code and Standards* | to note | 13.40-13.50 |
| C-310315-7 Performance Report including the Annual Registration Report* | to note | 13.50-14.15 |
| C-310315-8 Budget update  
- Review of the Budget 2015 and budget update* | to note | 14.15-14.45 |
| C-310315-9 Remuneration Committee paper* | to decide | 14.45-15.05 |
| C-310315-10 Audit Committee report | to note | 15.05-15.15 |
| C-310315-11 Review of Strategic Risk Register* | to note | 15.15-15.25 |
| C-310315-12 Workplan | to note | 15.25-15.30 |
| C-310315-13 AOB | | 15.30-15.35 |

**Date of next meeting - 18 June 2015**
MINUTES OF THE MEETING
OF THE GENERAL CHIROPRACTIC COUNCIL
HELD ON 1 DECEMBER 2014
44 WICKLOW STREET, LONDON WC1X 9HL

OPEN SESSION

Present:
Suzanne McCarthy (SM), Chair
Sophia Adams Bhatti (SAB)
Marie Cashley (MC)
Roger Creedon (RC)
Christina Cunliffe (CC)
Roger Dunshea (RD)
Tom Greenway (TG)
Gareth Lloyd (GL)
Julie McKay (JM)
Grahame Pope (GP)
Liz Qua (LQ)
Julia Sayers (LS)
Gay Swait (GS)

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

<table>
<thead>
<tr>
<th>Apologies and declarations of interest</th>
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<tbody>
<tr>
<td>No declarations of interest were made.</td>
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<thead>
<tr>
<th>C-011214-1</th>
<th>Draft minutes of meeting of 6 October 2014</th>
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<tbody>
<tr>
<td></td>
<td>The minutes of the October meeting were agreed as an accurate record subject to the following amendments:</td>
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</table>

The second paragraph of Item 3, page 3 under ‘Professional Association conferences’ should be amended to read, “She informed Council of a conversation she had had with Sue Roff, a researcher, at the IAMRA conference, who was interested in the ethical decisions taken by registrants and students. Ms Roff is conducting a project on that subject for the General Osteopathic Council (GOsC) and could prepare a similar project for the GCC. The Chief Executive said that he planned to discuss the work with Ms Roff and that a project, such as the one conducted for the GOsC, might be considered for inclusion in the Council’s research programme.” |
<table>
<thead>
<tr>
<th>C-011214-2</th>
<th><strong>Matters arising and Action log</strong></th>
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<tbody>
<tr>
<td><strong>Item 4, Advertising Standards Authority (ASA):</strong> The Chief Executive advised Council that he would circulate the response received from the ASA, as well as report on his meeting with Marc Thomas, Department of Health's Deputy Director of Professional Standards, who he was meeting on 9th December. It was also agreed that the subject of advertising should be included on the next joint GCC/Associations/Royal College meeting.</td>
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<td><strong>Item 4, Welsh Language Scheme:</strong> The Chief Executive advised Council that on 6 February all regulators would be advised of the new requirements regarding the Welsh Language Scheme. He would provide an update on this subject to Council's March meeting.</td>
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<tr>
<td><strong>Item 12, GCC Draft Annual Report:</strong> DH reported that the Annual Report had been circulated to Council members and the final report would also be emailed to them.</td>
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<tr>
<td><strong>Item 4, Duty of Candour:</strong> The Chief Executive reported that all regulators had now signed the statement. All registrants would be encouraged to admit when they were at fault and to take appropriate action to resolve any errors. At his recent meeting with the insurers it was reported that the Medical Defense Union had received advice that it was not a breach of policy to admit error, but that there was a legal obligation to rectify any wrongdoing.</td>
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</table>

**Action:** The subject of advertising to be on the agenda for the next joint meeting with the Associations and the Royal College of Chiropractic.

**Action:** ASA response to the GCC to be circulated to Council members.

**Action:** The Chief Executive to report on his meeting with Marc Thomas from the Department of Health.

<table>
<thead>
<tr>
<th>C-011214-3</th>
<th><strong>Chair’s Report</strong></th>
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<tr>
<td><strong>Recruitment for lay and registrant member</strong></td>
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<tr>
<td>The Chair reported that the appointment panel had met the previous week to longlist candidates and the recruitment agency was now meeting with these candidates. Interviews would be held on December 16th and Council would be advised of the new appointees after their appointments had been confirmed by the Privy Council.</td>
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**Board members appraisals, board effectiveness and governance** |
| The Chair suggested that discussions about board effectiveness could be included when she discussed each individual Council member’s appraisal. This was agreed. Individual meetings would then be arranged in the new year. |

**Healthcare regulators chairs’ meeting** |
| The Chair reported on the recent meeting of the Healthcare Regulators chairs. The main item of discussion was the PSA’s review process. A further meeting with Baroness Pitkeathly, Chair of the PSA, and Harry Cayton, PSA Chief
Executive, and the Chairs and Chief Executives of all the healthcare regulators was scheduled for 12 January 2015.

The Chair also informed Council that both she and the Chief Executive would be attending the PSA annual symposium in February. The Symposium's central theme was complaints, as this was an issue which was occupying the minds of all the healthcare regulators. It was also expected that the subject of Duty of Candour would be raised at the symposium.

Professional Association conferences
The Chair reported that she had attended both the UCA and the McTimoney conferences and said that, at both, there had been a positive exchange between regulators, registrants and education providers.

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<tr>
<th>C-011214-4</th>
<th><strong>Chief Executive’s Report</strong></th>
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<tr>
<td><strong>Law Commission’s proposals</strong></td>
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<tr>
<td>The Chief Executive updated Council on the Law Commission’s proposal, which the Department of Health supported. It was not certain when the Bill would be introduced in Parliament.</td>
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<td><strong>Indemnity Insurance work programme</strong></td>
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<tr>
<td>He advised Council that Parliament had decided to extend and develop indemnity arrangements. In future, registrants would be able to make arrangements other than insurance to indemnify themselves. The office is currently liaising with our legal advisors, who are drafting the new rules.</td>
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<td><strong>European Chiropractic Union (ECU) meeting</strong></td>
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<td>The Chief Executive reported on the very informative ECU meeting he recently attended in Stockholm, which he described as being very informative. At the meeting he was informed that French chiropractors had made the decision to withdraw from the European Chiropractic Union.</td>
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<tr>
<td><strong>Meeting with the Department of Health</strong></td>
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<tr>
<td>The Chief Executive informed Council of his forthcoming meeting at the Department of Health hosted by Marc Thomas, Deputy Head of Professional Standards. He and the Director of Education, Registration and Standards would be in attendance at the meeting to discuss such topics as legislation, whistleblowing, revalidation and enabling excellence.</td>
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<tr>
<td><strong>Conferences</strong></td>
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<tr>
<td>The Chief Executive also reported that he had attended both the UCA (with the Chairman) and SCA conferences.</td>
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<tr>
<th>C-011214-5</th>
<th><strong>Performance Report (including Financial Report)</strong></th>
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<tr>
<td>The Deputy Chief Executive introduced the Performance Report. In doing so, he mentioned that Council had agreed to defer consideration of the Governance manual to 2015. This was because the GCC was waiting on information from the GCC’s lawyers which was vital for completion of the manual.</td>
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<tr>
<td><strong>Equality and Diversity</strong></td>
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<tr>
<td>An update was provided on the GCC’s work in the area of Equality and Diversity and progress made in this area. The GCC had received its audit report from UKIED, the external provider appointed to review the GCC’s Equality and</td>
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Diversity policy and had appointed an Equality and Diversity officer. The short-term recommendations contained in the report had been completed and the GCC would be meeting the external consultant in December to progress this work. A further meeting would be held early in 2015 when the consultant would identify other areas that needed to be expanded upon. The GCC planned to work towards implementing those proposals within a 3-6 month period.

He mentioned that another item in the Operations Plan that was yet to be completed was the CoP and SoP review. He reminded Council that it had agreed a change in the timetable for this work, which was now due for completion in early 2015. It was noted that there was therefore an associated delay in the Review of the Criteria for Recognition of Degrees.

**Action:** Equality and Diversity update to be provided to Council in March 2015.

KPIs
The Deputy Chief Executive explained that there were two KPIs showing red: listing 90% of PCC hearings within nine months of referral; and managing expenditure levels within 5% of the budget. With regards to the former, he confirmed that the target of 90% would not be met in 2014 but that the GCC expected to meet the target by the second quarter of 2015. Regarding the latter, the expenditure level was currently 12% below the budgeted level.

Council asked that an additional column be added to the report which would provide information on what progress, if any, had been made since the previous periods.

**Action:** Additional column to be added to the Performance report, providing information on progress from prior reports.

Financial Report
The Deputy Chief Executive explained that, as of October 2014, income was down by approximately £40k, a large proportion of which was related to the level of investment income achieved.

He reported that more new registrants had registered on the non-practising register than was expected, but there was not currently enough data to explain this. It was suggested that it might be helpful to ask for more information from the education institutions, as some of them gathered information about students’ intentions before they graduate which might provide some insight. Some Council members also felt that it might be better for more conservative estimates regarding initial registration to be used in future. Further, 2015 registration data would be available from January 2015, which could be included in the financial monthly reports.

Expenditure
With regards to expenditure, the Deputy Chief Executive said that office costs and professional fees had reduced. There were two reasons for the reduction in professional fees; some projects had cost less than expected and some had moved to 2015. Cost savings had also been made in the area of regulation. The GCC now had a full in-house legal team and savings in this area had been greater than anticipated.

Overall, a deficit position of £114k was forecast, as opposed to the original
<table>
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<tr>
<th>C-310315-1</th>
<th><strong>Remuneration Committee</strong></th>
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<tr>
<td><strong>The Chair of the Remuneration Committee explained that Liz Qua had attended the Committee’s last meeting in place of Sophia Adams Bhatti, as had the newly appointed Committee member, Sylvia Doyle.</strong></td>
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<td><strong>He reported that the Committee had agreed a 2% pay increase for staff whose performance had been satisfactory. The Chief Executive was given the option to award a further discretionary 1% to those members of staff who had performed particularly well.</strong></td>
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<td><strong>The chair said that the future work programme of the Committee would include a review of the payments made to statutory Committee and Council members.</strong></td>
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<td><strong>The Remuneration Committee asked the Council to agree a change to the Committee’s terms of reference in that a Committee meeting would be considered quorate with one registrant, one lay person and the independent member of the Committee attending.</strong></td>
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<td><strong>Council asked that a short paper be presented to the March Council meeting, which would include details of the Committee’s work programme, together with the pros and cons of the proposal to change the Committee’s terms of reference.</strong></td>
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<tr>
<td><strong>Action: A paper on the work programme of the Remuneration Committee and proposed changes to its terms of reference to be presented to the March Council meeting in March 2015.</strong></td>
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<tr>
<th>C-31214-7</th>
<th><strong>Business Plan 2015</strong></th>
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<tr>
<td><strong>The Deputy CE introduced the proposed 2015 Business Plan which had been presented to Council at the previous meeting. He noted that changes requested at that meeting to Strategic Aim 3, regarding international stakeholders, had been incorporated.</strong></td>
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<td><strong>Further changes were agreed by Council at the meeting, which were:</strong></td>
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<td>• Strategic Aim 1.3 would be removed, as it was duplicated in strategic aim 4.1;</td>
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<td></td>
<td>• Strategic Aim 3.2 amended to read, “Continuing to maintain constructive dialogue with our domestic and international stakeholders”; and</td>
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<td></td>
<td>• Strategic Aim 4.2 amended to read, “Develop our E&amp;D work in all functional areas”, in order to improve the clarity of the statement.**</td>
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It was noted that the strategic aims communicated the GCC’s aims but their delivery was subject to resourcing restraints, which Council would review during the course of 2015. The Executive would be drafting an Operational plan with deadlines.

**Budget and Capital Plan 2015**

The Deputy CE introduced the draft Budget and Capital Plan for 2015, which had been presented to Council at the previous meeting. At that meeting the expected surplus of £20k had been reduced to £10k. Since then, £30k had to be included to cover the unanticipated expense of the Council appointment process. However, there had been savings made in areas such as office costs which helped to cover this unexpected expense.

He said that income was expected to increase from the 2014 budget by 3.3%, and that expenditure was expected to reduce by 7.8%, largely due to efficiencies put in place, specifically in the area of FtP.

It was, however, expected that the requirement for temporary staff would be higher in 2015, to accommodate the GCC’s work requirements. The IT budget had also been increased, in order to provide the funding needed to update the website and database.

Accommodation costs had been reduced, due to less planned hearing days in 2015. The GCC hoped to reduce this cost even further by working with other regulators to obtain lower daily rates for hearing accommodations. Investigating Committee costs had been reduced to £70k and there had been a reduction achieved in Professional Conduct Committee costs from £705k to £495k. This had been made possible by the employment of a full in-house legal team who were preparing, investigating and presenting cases.

The PSA levy for the period April-December had been included in the budget, along with legal fees of £54k and project and consultancy fees of £70k, based on planned projects for 2015. Human resource costs had been reduced to £5k, based on expected requirements. Council costs were expected to increase due to Council member appointments in 2016.

The overall position showed a £10k surplus for the year.

The Council agreed to adopt the budget, with the proviso that it would be reviewed in March 2015, where it would be re-examined to determine if the expected income was over optimistic and if the information on which the budget was based needed adjustment.

**Action:** Review the budget in March 2015

**Cazenove – Investment update**

Jeremy Barker and Rory Cumming, from Cazenove, provided Council with an update on the GCC’s investment portfolio. As at 25th November 2014 the portfolio value was just over £4,237k, reflecting a growth of around £237k. Additionally, the GCC had also received £90k of income from the portfolio. Estimated income for the whole year was £114.
The Chief Executive introduced the proposed Research Strategy and research plan for 2015. He noted that at point 3 under ‘Priority’, the second sentence should read, “The Executive’s view is that it would be sensible for us to conduct the two studies specifically recommended in Sally Williams report”. Additionally, Principle 1e should be amended to read, “.... we should examine if the results can be safely applied to the regulation of the chiropractic profession....”.

At point 5 of the Annual Review section, he noted that it had been decided that the research strategy should be reviewed in September rather than in December.

He advised that Council had previously seen the draft paper and reviewed the principles contained in the paper, which Council had agreed, pending the following amendment: Principle 1d to be amended to read, “the GCC should not usually undertake research which should be conducted by others”.

The Chief Executive explained that the proposed research projects were in line with the GCC’s proposed aims. Once the projects had been agreed, resourcing would then be considered.

The Chief Executive confirmed that the projects in the appendix had been listed in order of priority. He also said that the aim was to prioritise the recommendations contained in the Sally Williams’ report. Council noted that some of the work would require more than one year to complete, while other projects would be expected to be completed within a twelve-month period.

In relation to Education, the first item listed involved considering a study conducted by Sue Roff of Dundee University, similar to the one the GOsC had been carrying out. The Chief Executive explained that there would be some costs associated with this item which was listed under Education as “Promoting professionalism”. The estimate was around £6k, but the amount could only be confirmed once a detailed proposal had been received.

Council agreed that the heading, ‘Proposed research for 2015,’ should be changed to ‘Proposed Research Programme’. Council decided that the Research Programme should be delivered over the next three years.

The Policy and Communications Manager introduced the paper on the proposed core messages for the Council’s communication activity.

He noted that clear message about the GCC were emerging which were already being used in media articles and speeches by both the Chair and the Chief Executive. These centred around the three themes contained in the paper: we aim to deliver effective regulation for the protection of patients and the public; we wish to work proactively with the profession to improve standards while those who contravene our requirements can expect us to take action against them; and implementation of the Law Commission’s recommendations would allow us to improve the delivery of our functions.

Responding to a comment that the need for legislative change should be more explicitly stated, the Policy and Communications manager said that ‘message
three’ covered the importance of a change to the legislation. He stressed that the intention wasn’t that the messages would be used verbatim, but that they would be tailored for the particular audience being addressed.

It was further agreed that message three should be redrafted to read “implementation of the recommendations of the Law Commission’s proposed bill would address many of these issues, and allow us to reflect the needs of both registrants and patients.”

C-011214-12 **Risk Register**

The Chair of the Audit Committee advised that the minutes from the last Audit Committee meeting had been circulated to Council. He said the Committee thought the GCC’s Whistleblowing Policy which, though in its final stages, still required further work, particularly about external and internal risk factors.

He said that the Audit Committee had also discussed the Strategic Risk Register. The principal item considered was the Continuing Fitness to Practise CPD project, with a specific focus on how well this could be delivered. Another key area was the CoP and SoP review, as the outcome of that work would be critical in terms of the GCC’s standards of regulation. It was also important the Committee thought about how communications around the CoP and SoP could be delivered effectively.

The Chair advised Council that the Committee intended to keep a close watch on risk factors associated with such areas as registration fees and the investment portfolio.

He explained to Council that the Committee had received assurance that operational risks were being well managed.

The Committee had also discussed the process for appointing the GCC’s external auditors in 2015. He explained that the Committee planned to complete a tender exercise in the first quarter of 2015.

It was noted that, in the review of the Governance manual on page 37, it should state that it would be reviewed in March 2015, rather than December 2014. Under ‘Failure to uphold standards’ on the same page, an additional sentence should be added to so that the statement under ‘further actions’ should read, “Council will review the proposed CoP/SoP at a seminar session in March 2015 prior to its meeting. It then needed to be considered for approval in June 2015”.

C-011214-13 **Review of the Workplan**

Council discussed the workplan and agreed to amend it as follows:

- Board effectiveness, research proposals, the budget update and the Remuneration Committee’s proposal to be presented in March;
- The review of retention fees to take place in September rather than March;
- The ‘Annual Report’ item for September should read ‘Annual Report and Accounts’; and
- The presentation from Cazenove to take place annually in December.
Additionally, the Performance Report would be emailed to Council in the last week of each month.

**Action:** Workplan to be updated according to agreed amendments.

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<thead>
<tr>
<th>C-011214-14</th>
<th>AOB</th>
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<tbody>
<tr>
<td><strong>Newsletter</strong></td>
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<tr>
<td>Council discussed a recent article concerning a registrant who had been removed from the register and, in particular, in light of Council's duty to advise the public of such cases, how such reports might be written.</td>
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<tr>
<td>Council agreed the following items for inclusion in the next newsletter:</td>
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<tr>
<td>• Research Strategy;</td>
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<td>• Business plan and budget; and</td>
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<td>• The importance of reducing complaints and the cost involved in complaints.</td>
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<td>The GCC confirmed the intention to issue bi-monthly newsletters.</td>
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<td><strong>CPD</strong></td>
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<td>A Council member asked whether the CPD submission requirements had changed. It was confirmed that the requirements remained the same as from previous years. The Director of Education, Registration and Standards explained that the GCC had put more resourcing into CPD this year. Some registrants' submissions had needed further clarification or expansion where, for example, registrants had been required to explain their learning needs and the impact of that learning on their professional development. She noted that, generally, it was not course content that had been called into question but rather, the way the learning needs had been met by courses undertaken. She advised Council that the Education Committee would further explore the subject of CPD. An article would be included in one of the 2015 newsletters so that registrants would understand what was required of them.</td>
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<tr>
<td><strong>Test of Competence update</strong></td>
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<tr>
<td>The Director of Education, Registration and Standards reported that all appointed assessors for the Test of Competence (ToC) had now completed their training and that the first ToC was scheduled for January 2015. Three other dates were also planned for 2015.</td>
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**Date of next meeting**

31st March 2015
<table>
<thead>
<tr>
<th>ITEM</th>
<th>ACTION</th>
<th>WHO</th>
<th>BY WHEN</th>
<th>STATUS</th>
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<tbody>
<tr>
<td>2.1</td>
<td>The subject of advertising to be on the agenda for the next joint meeting with the Associations and the Royal College of Chiropractic.</td>
<td>Executive</td>
<td></td>
<td>Completed</td>
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<tr>
<td>2.2</td>
<td>ASA response to the GCC to be circulated to Council members.</td>
<td>CER</td>
<td>March 2015 Council meeting</td>
<td>CE to update Council at March meeting</td>
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<tr>
<td>2.3</td>
<td>The Chief Executive to report on his meeting with Marc Thomas from the Department of Health.</td>
<td>CER</td>
<td>March 2015 Council meeting</td>
<td>On March agenda</td>
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<tr>
<td>5.1</td>
<td>Equality and Diversity update to be provided to Council in March 2015.</td>
<td>CER</td>
<td>March 2015 Council meeting</td>
<td>On March agenda</td>
</tr>
<tr>
<td>5.2</td>
<td>Additional column to be added to the Performance report in relation to KPIs, providing information on progress from prior reports.</td>
<td>DCE</td>
<td>March 2015 Council meeting</td>
<td>Completed</td>
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<tr>
<td>5.3</td>
<td>An updated report on the registrant profile to be brought to Council.</td>
<td>CER</td>
<td>March 2015 Council meeting</td>
<td>Report on March agenda.</td>
</tr>
<tr>
<td>5.4</td>
<td>Council to discuss what needs to be included in future financial Reports.</td>
<td>Executive</td>
<td>June 2015 Council meeting</td>
<td>On June Council agenda.</td>
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<tr>
<td>6.1</td>
<td>A paper on the work programme of the Remuneration Committee and proposed changes to its terms of reference to be presented to Council</td>
<td>Remuneration Ctte Chair</td>
<td>March 2015 Council meeting</td>
<td>Paper completed and item added to March agenda.</td>
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<tr>
<td>8.1</td>
<td>Review of the budget</td>
<td>DCE</td>
<td>March 2015 Council meeting</td>
<td>On March agenda</td>
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<td>13.1</td>
<td>Workplan to be updated according to agreed amendments.</td>
<td>Executive</td>
<td>March 2015 Council meeting</td>
<td>Completed – except for research proposal item which has been moved to June.</td>
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</table>
To: The General Chiropractic Council  
From: Penny Bance, Director of Education, Registration and Standards  
Subject: Student Fitness to Practise and Pre-registrant professionalism research  
Date: 31st March 2015

Purpose

1. The purpose of this paper is to provide Council with an update on the research project on student fitness to practise and pre-registrant professionalism approved by Council at its meeting in December 2014.

2. A presentation will have been given to Council on 30th March by Sue Roff, Medical Educationist from the University of Dundee.

3. Phase one of this research focuses on students and will commence in April 2015. Phase two will focus on registrants and will commence later in 2015 once the new Code has been approved.

Background

4. The Council approved a research strategy and three year research programme at its meeting in December 2014. The overarching theme of the research strategy is professionalism and several strands are proposed for the education area.

5. One of the proposed areas of research builds on work that the General Osteopathic Council has been carrying out with their students and registrants in conjunction with a medical educationalist from the University of Dundee, Sue Roff. This work has led to the development of professionalism tools, which have been used with education providers for pre-clinical and clinical students in several healthcare disciplines and most recently with registered osteopaths.

6. The award of a recognised qualification leading to registration with the GCC, subject to health and character requirements, means that a student has reached the required standard of proficiency, with a commitment to abide by ethical and other standards stated in the published Code of Practice. These standards are currently being revised.

Student fitness to practise

7. The GCC defines student fitness in its publication, Student Fitness to Practise: Guidance for Students (May 2012) as:

‘having the necessary health and character to demonstrate that you will have the capability to practise safely and effectively once you are registered. This will be demonstrated by how you behave towards patients, other students, staff and
others; how you act during your education and training programme and in your personal life; and how you conduct yourself generally within the programme’.

8. The GCC publication, states that:

‘we realise that you are in a learning situation and are in the process of developing into a professional. In this sense your knowledge and understanding of professional behaviour will change, develop and mature over time. The ethical complexities of healthcare, and the situations you encounter during your course, will contribute to your development as a professional and to your fitness to practise. This means that the expectations placed on your fitness to practise will increase as your course goes on, and your fitness to practise will be of specific concern when you are in the clinical phase of your training. However, this is not an excuse to behave inappropriately while you are in the early years of your programme. We, like your education provider, will have concerns about any behaviour at any time (whether on a course or in your private life) that raises questions about whether you will be fit to practise as a healthcare professional.’

In table 1, Annex 1 below, there is a description of the professional behaviour that is expected of students and behaviour that would give cause for concern.’

9. The complementary GCC ‘Student Fitness to Practise: Guidance for Education Providers (May 2012) states that ‘education providers are expected to ‘actively develop student fitness to practise’ and that ‘The GCC is aiming for a consistency of approach to student fitness to practise across all its recognised chiropractic degrees.’

10. The Guidance sets out the education providers’ responsibilities in Developing Student Fitness to Practice (sections 18-26) being:

• Communication and awareness raising of professional values;
• Developing and assessing professionalism through the learning curve of their pre-registrant training; and
• Developing and evaluating all aspects of the educational environment including the ‘hidden curriculum’.

Tools for measuring professionalism

11. There are currently no tools to measure professionalism either at undergraduate level or for registered chiropractors. In the light of the research by Sally Williams in 2014, which identified poor professional attitudes as a reason for FTP complaints, Council decided to focus research on professionalism and an analysis of professional attitudes and the steps needed to rectify any deficiencies revealed by the evidence.

12. The education providers whose programmes are recognised by the GCC have a duty to emphasise the academic and professional aspects of practice during undergraduate education. The tools proposed in this programme of work could help both students and chiropractors to reflect on professional behaviours supporting the development of good practice.

Working with Sue Roff to develop an on-line resource

13. As Council is aware, we will work with Sue Roff (see CV at Annex 2) to develop an on-line resource to help education providers support their students in meeting the GCC’s professionalism expectations, to support understanding of views about professional behaviour within and between education providers and
to develop e-learning tools to support students to learn professional behaviours, including appropriate knowledge, skills, attitudes and values. Comparisons may be possible with other healthcare students as Sue Roff is able to demonstrate.

**Proposed Timeline and resources for Phase One**

14. The following timeline is proposed for discussion at Education Committee and with the education institutions:

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>Project Commences</td>
<td>GCC and Sue Roff (SR)</td>
</tr>
<tr>
<td>23rd April</td>
<td>Meeting with Education Institutions</td>
<td>Education Committee</td>
</tr>
<tr>
<td>May</td>
<td>Conversion of Inventory to Chiropractic</td>
<td>SR</td>
</tr>
<tr>
<td></td>
<td>Purchase BOS licence</td>
<td>GCC</td>
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<tr>
<td></td>
<td>Launch of link by GCC</td>
<td>GCC</td>
</tr>
<tr>
<td>June/July/Aug</td>
<td>Data collection by education institutions</td>
<td>Education Institutions (EIs)</td>
</tr>
<tr>
<td></td>
<td>Analysis of responses</td>
<td>SR</td>
</tr>
<tr>
<td></td>
<td>If all going well…..</td>
<td></td>
</tr>
<tr>
<td>Sept/Oct</td>
<td>Re-administer data collection and analyse</td>
<td>EIs and SR</td>
</tr>
<tr>
<td>11th November</td>
<td>Disseminate results to institutions at Education Committee meeting</td>
<td>GCC and SR</td>
</tr>
<tr>
<td>December</td>
<td>Write up results for article submission and report to Council Evaluation Plan for 2016, on-going collection of data from students</td>
<td>GCC and SR</td>
</tr>
</tbody>
</table>

15. As indicated in the research programme approved by Council in December 2014, there would be external consultancy costs for this work. 9 days (1 day per month) @ £500 + T&S for 2 meetings (£500) for Sue Roff = £5000  
Plus annual software licence @ £600 + VAT  
A total of around £6000.

The costs are exceptionally low due to the research and development work on these tools that Sue Roff carried out with GOsC during 2014 for which we therefore do not have to pay.
Phase 2 – Promoting professionalism and professional behaviours for registrants

16. Once the new Code has been approved and published and linked to CPD, the GCC will conduct complementary research and development exploring professionalism in professional practice.

17. This would provide an on-line learning resource using situational judgements that will provide active learning opportunities; give feedback for formative learning; and allow the analysis of the responses to enable the GCC to understand and monitor the professionalism of its registrants.

18. Ahead of the new Code going ‘live’ in 2016, a pilot could be carried out with several surveys exploring professional dilemmas in chiropractic and a revision quiz testing knowledge of the new Code. The scenarios and questions would aim to support awareness and understanding of the new Code and its application in practice and form part of our implementation plan for the new Code. The professionalism issues identified by Sally Williams in her report could also be considered for online learning.

19. The anticipated benefits of this work are:
   • e-learning and collecting data from chiropractors and other healthcare professionals can help to bring norms together across professions and professional groups through feedback, dialogue and reflective learning;
   • Working in partnership with individuals and organisations can help the GCC and the profession to develop strategies to support co-ordinated approaches to implementation of guidance and deal with identified lapses in professional norms, behaviour and standards;
   • applying a more proactive approach to regulation than has to date existed in healthcare regulation in general.

20. Further resource would be required for this phase of research with external consultancy days and an Articulate software licence fee.

Equality Implications

21 Equality and diversity issues will be considered throughout the research project.

Communications Implications

22 Some communication activities have been included in the project plan and further activities will be considered during the project and consideration given as to how the work will inform our development of guidance for both students and registrants and discourse around possible areas of dissonance in views. The GCC newsletter will also be used to inform stakeholders of this research.

Action required

21. The Council is asked to note the update.

Penny Bance
Email: p.bance@gcc-uk.org
### Table 1: Professional behaviour expected of chiropractic students and that which would give cause for concern (GCC Student Fitness to Practise: Guidance for Students, May 2012)

**A  You must respect patients’ dignity, individuality and privacy**

There would be concerns if you:
- used inappropriate language or behaviour
- disclosed information about patients or other students to anyone who was not entitled to it (that is, if you breached confidentiality)
- identified patients or made comments about them on social media sites
- talked about individuals or groups of people in a derogatory way at any time on your course

**B  You must respect patients’ rights to be involved in decisions about their healthcare**

There would be concerns if you:
- had poor communications skills and found it difficult to relate to patients, other students or staff
- were rude to patients, other students or staff
- did not get consent from a patient or another student before assessing or treating them
- did not complete patient records, left important information out of records or invented aspects of the records

**C  You must justify public trust and confidence by being honest and trustworthy**

There would be concerns if you:
- cheated in any way, including plagiarising academic work (passing it off as your own work)
- acted dishonestly (for example, by making dishonest claims about your qualifications, experience or status; or lying about the reasons for being absent)
- misled patients, their carers or the public in any way (for example, about what chiropractic can achieve)
- asked someone else to do work on your behalf, which you then claimed to be your own; or did work for another student which they then claimed to be their own
- signed in for other students and therefore lied on their behalf
- had a criminal conviction or caution for acting dishonestly or being untrustworthy (for example, for theft or financial fraud)
- used internet and social networking sites in a way that might bring the profession into disrepute.

**D You must provide a good standard of practice and care**

There would be concerns if:
- your timekeeping and attendance were poor
- your attitude was poor and you were not willing to carry out the required duties and tasks
- you did not follow instructions from college staff or supervisors
- you did not respond to staff who were trying to contact you or talk to you about an issue
- you tried out techniques on patients or other students that you had not been taught or were not skilled enough to use
- you practised chiropractic at times when you were not appropriately supervised

**E You must protect patients and colleagues from risk of harm**

There would be concerns if you:
- exposed patients or other students to risk of harm
• disobeyed any of the education institution’s policies and procedures
• had a criminal conviction or caution related to sex offences, including being involved with child pornography
• had a criminal conviction or caution related to physical violence
• had misused drugs or alcohol, were dependent on them or had a criminal conviction or caution related to drugs or alcohol
• displayed aggressive, violent or threatening behaviour to anyone
• had a persistent inappropriate attitude towards your work, both professionally and academically
• showed a lack of insight into your health condition or disability and neglected its management

F You must cooperate with colleagues from your own and other professions
There would be concerns if you:
• used inappropriate language or behaviour
• disclosed information about patients or other students to anyone who was not entitled to it (that is, if you breached confidentiality)
• identified patients or made comments about them on social media sites
• talked about individuals or groups of people in a derogatory way at any time on your course
SHORT CURRICULUM VITAE
Sue Roff
Education Consultant

Address: 29 Shore Street, Cellardyke, Fife KY10 3BD Scotland
Tel. 01333 312131; s.l.roff@dundee.ac.uk

Qualifications: M.A. (Thesis) Monash University, Australia 1973
B.A. (First Class Hons) University of Melbourne, Australia 1969

Professional Service Appointments

2005-2007 Lay Member, Modernising Medical Careers Delivery Group for Scotland
2005-2009 Peer Reviewer, Scottish Executive Environmental and Rural Affairs Department Science and Research Group
2004-2007 Lay Member, Medicine Advisory Group, NHS Education for Scotland
2004-2011 Deputy Chair and Non-clinical scientist member, Tayside Research Ethics Committee
2005-2007 Lay Member, Scottish Faculty of Advocates Disciplinary Tribunal
2003-2010 Scottish lay member, Postgraduate Medical Education and Training Board/Chair Audit Committee 10/05 –11/07; member through to April 2010 merger with GMC
2003-2006 Lay Member, Unrelated Live Transplant Regulatory Authority
2001- Lay Member of GMC Fitness to Practice Committee and Investigation Committee and Registration Panel
2007-2013 Public Interest Member, Regulation and Compliance Board of Institute of Chartered Accountants of Scotland Chair of short term working group into Charities sector accounting; member of CPD short term working group.
2009-2013 Member, Education Committee of General Optical Council
2013- Member of Editorial Board of Health and Social Care Education, online publication of Higher
Education Academy Health and Social Care cluster.

2013- Assessment Lead, Education Advisory Committee, St John Ambulance

2014- Lay Visitor, Health and Care Professions Council

2015 - Lay member, Midwifery Committee of Nursing and Midwifery Council

Employment

Educational Consultant, General Osteopathic Council

2012- Part Time Tutor, Centre for Medical Education, University of Dundee Medical School

9/91 – 1/2012 Project Development Officer/Senior Research Fellow, Centre for Medical Education, University of Dundee Medical School
http://medicine.dundee.ac.uk/news/retirement-sue-roff


1980-1991
- Programme Consultant, Franklin and Eleanor Roosevelt Institute, New York;
- Non Governmental Representative to the United Nations for Minority Rights Group, New York;
- Grant Advisor, The Hunt Alternatives Fund, New York

1977-79 Freelance Journalist and Editor in New York


1971-1974 Lecturer (tenured), Faculty of Education University of Melbourne, Australia

1970-1971 Teaching Fellow, Department of Politics, Monash University, Australia.

Research and Teaching: Supervised more than 100 Masters theses; more than 50 publications in Medline; nearly 100 publications of secondary research following my co-development of Educational Environment measures are reported in Medline – also regular sessions at international conferences devoted to these measures.
Recent Conference Presentations

- **Designing Professionalism Induction eLearning for International Medical Graduates** to *International Association of Medical Regulatory Authorities* conference, London September 2014
- Invited Keynote Speaker on **Enhancing Medical Education Culture: Living the DREEM** to the *Korean Medical Education Congress*, Seoul May 2014.
- **Changing Cultures: using formative calibrated feedback loops** to create communities of e-learning and practice for healthcare team Professionalism to *Improving professional regulation in health and social care: interdisciplinary insights* Professional Standards Authority Conference, Cumberland Lodge, Windsor March 2014

Recent Publications

- Roff S and McAleer S. "Towards Robust Validity Evidence for Learning Environment Tools" Letter to Editor Med Teach. forthcoming in *Academic Medicine*
- Roff S. Reconsidering the ‘decline’ in medical student empathy as reported in studies using the Jefferson Scale of Physician Empathy – Student Version *Medical Teacher* online February 10, 2015
  - Roff S and McAleer S. “Robust DREEM Factor Analysis” Letter to Editor *Medical Teacher* 2014 Oct 1:1
- Browne F, Rolfe K, Currie A, Walker T, Roff S. Adapting and feasibility testing a pre-registration e-learning resources for Professionalism in Osteopathy in the UK. Forthcoming in *International Journal of Osteopathic Medicine*
- Babelli S, Chandraatilake M and Roff S. Recommended Sanctions for Lapses in Professionalism by Student and Faculty Respondents to Dundee Polyprofessionalism Inventory I: Academic Integrity in One Medical School in Saudi Arabia. *Medical Teacher* Early online August 26, 2014
- Babelli S. Chandraatilake M and Roff S. Egyptian Medical Students’ Recommended Responses to the Dundee Polyprofessionalism Inventory I: Academic Integrity, *Medical Teacher* Early online August 26, 2014
- Jalili M, Mortaz Hejri S, Ghalandari M, Moradi-Lakeh M, Mirzazadeh A, Roff S. *Validating modified PHEEM questionnaire for measuring educational*

  - Roff S. “Is it time to pay for kidneys?” British Medical Journal August 2, 2011; 343
  - Burke S and Roff S. The GP trainees’ day release course and the new curriculum and MRCGP examination: responding to the changes. Education for Primary Care 2011 22(2):106-8
  - Roff S and Dherwani K. Development of Inventory for Polyprofessionalism Lapses at the Proto-professional Stage of Health Professions Education together with Recommended Responses. Medical Teacher 2011; 33(3):239-43

Also publications in inter alia The Lancet, Journal of Occupational and Environment Medicine, Journal of Medical Ethics, Bulletin of the Atomic Scientists. 50+ publications in MEDLINE

Publications to date using Dundee Polyprofessionalism inventories:

- Browne F, Rolfe K, Currie A, Walker T, Roff S. Adapting and feasibility testing a pre-registration e-learning resources for Professionalism in Osteopathy in the UK. Forthcoming in International Journal of Osteopathic Medicine
- Babelli S, Chandratilake M and Roff S. Recommended Sanctions for Lapses in Professionalism by Student and Faculty Respondents to Dundee Polyprofessionalism Inventory I: Academic Integrity in One Medical School in Saudi Arabia. Medical Teacher Early online August 26, 2014
• Babelli S. Chandratilake M and Roff S. Egyptian Medical Students’ Recommended Responses to the Dundee Polyprofessionalism Inventory I: Academic Integrity, Medical Teacher Early online August 26, 2014
• Is Professionalism Fractal-like? Letter to Editor, Medical Teacher 2014 Jul 29:1.
• Roff S, Chandratilake M, McAleer S, Gibson J. Medical student rankings of proposed sanctions for unprofessional behaviours relating to academic integrity: results from a Scottish medical school. Scottish Medical Journal 2012;57(2):76-9
• Roff S and Dherwani K. Development of Inventory for Polyprofessionalism Lapses at the Proto-professional Stage of Health Professions Education together with Recommended Responses. Medical Teacher 2011; 33(3):239-43
To: GCC Council
From: David Howell, Chief Executive
Subject: Complaints to the GCC about advertisements by registrants
Date: 31 March 2015

Purpose

1. During January 2015, the GCC received complaints about the content of 43 chiropractors’ websites.

2. In view of the need for an immediate decision on how these matters should be handled, I discussed in detail our proposed approach which is explained below with the Chair of Council, which she endorsed. In accordance with GCC Standing Orders, this matter is now reported to you.

Background

3. As a separate item on the agenda, Council has an opportunity to discuss the changes we have needed to introduce to our FtP processes as a result of the High Court’s decision in the Spencer case, which explains legally what can amount to an allegation of unfitness to practise. A letter on this subject was circulated to Council members.

4. Allegations against a chiropractor of making inappropriate claims on a website or otherwise, of course, like any other complaint of unprofessional conduct, fall to be determined by the general principles explained in the Spencer case.

5. However, there is one specific issue relating to complaints about advertising which, although not unique, affects their handling. Improper advertising is one of a number of allegations which can sometimes be made against chiropractors where other agencies or organisations may also be empowered to examine the same allegations or some aspects of them.

Concurrent jurisdiction

6. Where more than one authority has the power, and sometimes even the duty, to examine the same facts, aspects of “concurrent jurisdiction” can sometimes arise. In respect of allegations against chiropractors arising from a website advertisement, both the Advertising Standards Authority (ASA) and the GCC, generally speaking, have the power to examine the facts of the case.

7. Another example of another agency with an interest in the same facts is when an allegation is made to us against a registrant, which could also amount to a criminal offence as well as unprofessional conduct. Both the police and the GCC have the power to investigate the same facts.
8. Where more than one organisation has potentially jurisdiction to investigate and/or determine the same issue, it is both sensible and lawful for one organisation to decide to allow the other to investigate and deal with the case in the first instance. This is especially true when one organisation has a particular expertise or speciality in the subject matter of the potential investigation.

9. A recent example of this practise in the public domain was the use of the Attorney General’s policy in the so-called “Danny Boy” case which was finally determined by a Public Inquiry reporting to Parliament just before Christmas. Both the civil and military systems of justice had jurisdiction to decide whether or not any British person should be prosecuted for ten alleged murders and allegations of torture in Iraq. In view of their particular understanding of military operations, the Attorney General’s policy was that the military authorities should decide whether or not to prosecute rather than the DPP. Their decision not to prosecute was effectively endorsed by a subsequent public enquiry which reported in December 2015.

10. The GCC effectively follows a similar practise in cases where the police have an interest in a potential allegation against a chiropractor. There is one exception to the GCC policy to await the results of the police investigation before considering whether any further action is required. This is where it is necessary to protect the public. In that situation the GCC will impose an immediate suspension order on the registrant.

11. In the past, however, the GCC has not adopted the same practise when dealing with advertising cases and instead of referring the matter in the first instance to the ASA, has dealt with these allegations by immediately referring them for formal FtP investigations.

Other regulators’ approach

12. No other healthcare regulator routinely refers advertising complaints for automatic FtP investigation. One regulator has, in fact, a policy to refer all advertising matters to the ASA. We do not believe, however, that, as a responsible regulator, we can have a policy of always referring matters to the ASA. Each case must be separately considered.

A new position – consequence of Spencer

13. It is recommended that advertising cases should generally be divided into three categories:

13.1. An allegation may be such that no further action is required or any involvement by the GCC (for example, where claims are made against someone who is not under our jurisdiction or the advertisement cannot reasonably be questioned). The complainant will be notified accordingly;

13.2. The website allegations raise such serious issues of professional conduct (as defined by the Spencer case) that they need to be investigated immediately by the GCC (in criminal cases, the GCC will on occasion take action before the end of a police investigation to protect the public).

13.3. All other advertising complaints will usually be referred to the ASA as the specialist agency. Once the ASA has concluded its determination, the case will be examined to see what, if any, further action needs to be taken by the GCC.

Recommendations

14. Council is invited to endorse these changes to our previous position.
To: Registrants  
From: Chief Executive & Registrar  
Subject: Fitness to Practice Explanation  
Date: 31 March 2015

Background

1. The GCC believes there is some misunderstanding about when the GCC will begin formal fitness to practise investigations.

2. This note is intended to assist registrants in understanding the effects both of a recent court decision and the GCC’s policy changes.

3. The GCC will now only commence a formal investigation when a complaint raises a serious issue about a registrant’s fitness to practise, as explained in the paragraphs below.

The legal position

4. In the public interest, the GCC is legally required to investigate allegations against registrants either of incompetent professional performance or unacceptable professional conduct, or both. Where it is determined there is a case to answer, an independent tribunal (the Professional Conduct Committee) decides whether or not the registrant concerned is fit to practice. The GCC’s aims throughout are to protect the public and maintain public confidence in the profession.

Professional incompetence and unacceptable professional conduct

5. The recent High Court case, Spencer v General Osteopathic Council [2012, EWHC2147] made it clear that the evidence required to establish professional incompetence must be of a high degree.

6. For example, a single instance of negligent treatment, unless very serious, would be unlikely to constitute professional incompetence. A case where a registrant had failed to take proper notes on two occasions, but had made a proper assessment of the patient, a proper plan for treatment and proper treatment was given, does not amount to incompetence or negligence of a high degree.

7. Further, according to the High Court case, to amount to unacceptable professional conduct the allegation must involve a degree of "moral blameworthiness".

Unfitness to practice based on a breach of the Code of Practice or Standard of Proficiency

8. If a chiropractor is found to be in breach of the CoP and/or the SoP, it does not mean that there will be an automatic finding of unfitness to practise. Any alleged breach of the CoP
and SoP is relevant in deciding whether or not a chiropractor is unfit to practise, and this High Court case decided that a breach of the Code is only a starting point and does not raise an automatic presumption of unfitness to practise.

List of allegations that will not usually be investigated

9. In the light of this court decision, as a general principle the GCC will not investigate allegations of the following matters since legally they do not amount to complaints of unprofessional conduct or professional incompetence. This list is not intended as a complete list of all allegations which are beyond the scope of fitness to practice processes. It is simply intended to clarify issues which have previously caused confusion and misunderstanding.

10. The complaints which the GCC will not usually investigate under its formal fitness to practice procedures include:

   a) Complaints solely about business disputes;
   b) Complaints solely about employment, contracts or business premises;
   c) Complaints solely about fees or costs of treatment unless there are allegations of dishonesty or an intent to deceive or mislead;
   d) Complaints brought solely to remedy a private grievance which does not raise issues of public protection, patients’ safety or the reputation of the profession;
   e) Vexatious complaints, which include, but are not limited to:
      - submitting repeated complaints, essentially about the same issue;
      - refusing to accept a decision on a complaint or raising issues which are not within the GCC’s remit despite having been provided with relevant information about our scope; or
      - complaining about or challenging an issue based upon a historic or irreversible decision or incident;
   f) Complaints which solely relate to a registrant’s personal life unless the complaint:
      - has the potential to bring the profession into disrepute;
      - could potentially affect public confidence in the profession;
      - relates to a conviction in the United Kingdom for a criminal offence;
      - relates to a physical or mental condition which seriously impairs a registrant’s ability to practise as a chiropractor; or
      - raises issues of public protection or patient safety;
   g) Minor or single complaints about note taking/record keeping unless there is evidence of “incompetence or negligence to a high degree”;
   h) Complaints which lie solely within the jurisdiction of another regulator and which should have been made to that regulator (as, for example, allegations relating to the treatment of animals); or
   i) Complaints which amount to a difference of professional opinion and do not raise issues of public protection or patient safety.
David Howell  
Chief Executive and Registrar  
General Chiropractic Council  
44 Wicklow Street  
London  
WC1X 9HL

11th March 2015

Dear David

Comparison of qualifications

Recent events have brought into focus how important it is for the General Chiropractic Council to demonstrate the status of its registerable qualifications to other regulatory and licensing bodies around the world.

From our knowledge of the chiropractic profession, we know that there is considerable confusion about how the GCC’s Criteria for Recognition compares with the various Councils on Chiropractic Education (CCE’s) standards in different jurisdictions around the world.

The CCE International (CCEI) has just completed a detailed comparative analysis of the CCE’s for the USA, Canada, Europe and Australasia and if this could be expanded to include the GCC’s criteria, then this would seem to be an excellent opportunity to make it clear to the International chiropractic community once and for all that the GCC upholds the highest standards of chiropractic education and patient care.

As a first step, we ask that the GCC asks the CCEI for a copy of their comparative standards analysis and undertakes a matching analysis with the GCC Criteria.

We would be grateful if this letter could be forwarded to all members of Council and placed on the Agenda of the next meeting of Council.

Yours sincerely,

Matthew Bennett  
BCA  

Berni Martin  
MCA  

Ross McDonald  
SCA  

Kevin Proudman  
UCA
Use of the courtesy title ‘Doctor or ‘Dr’

1. Nothing prevents chiropractors using the courtesy title ‘Doctor’ or ‘Dr’ if they wish to. However, chiropractors using the title must be careful not to mislead the public.

2. A courtesy title does not reflect academic attainment; instead, it is associated with professional standing. As a result, it is important that the use of ‘Doctor’ or ‘Dr’ by a chiropractor does not suggest or imply that they hold a medical qualification or a PhD when they do not.

3. There are, however, chiropractors, who also hold PhDs and are therefore entitled to use the title Dr as a reflection of their academic attainment, which may or may not be in an area related to chiropractic.

4. Internationally, Chiropractors across the world use the title ‘Dr’. In the USA chiropractors graduate with a Doctor of Chiropractic degree.

5. Doctors and dentists in the UK are permitted to use ‘Dr’ as a courtesy title and the RCVS is currently consulting on the proposal that all veterinary surgeons registered with the RCVS should be permitted to use the courtesy title ‘Doctor’ or ‘Dr’.

Penny Bance, Director of Education, Registration and Standards
p.bance@gcc-uk.org
To: The GCC Council  
From: The Education Committee  
Subject: Reviewing and developing the Continuing Professional Development (CPD) scheme to assure the continuing fitness to practise of registrants 
Date: 31st March 2015

Purpose

1. The purpose of this paper is to:
   a. update the Council on the progress made by the Education Committee in reviewing the current CPD scheme for registrants;
   b. recommend how the CPD scheme can be developed so that it offers assurance of the continuing fitness to practice of registrants; and
   c. seek the Council's agreement to a work programme for undertaking further development to enable Council to be in a better position to assure the continuing fitness to practice of registrants in the future.

Background

2. In February 2014, the Council put the development of a revalidation system on hold, suspended the Revalidation Working Group and tasked the Education Committee with leading on the review and development of the CPD scheme.

3. The Education Committee has taken forward a number of activities to review the current CPD scheme, investigate the broader context and explore the range of ways in which the continuing fitness to practise of registrants might be assured. These include:
   a. undertaking research into the current CPD market and the opportunities that are available for chiropractors' learning and development – see Appendix A;
   b. reviewing the current CPD scheme to determine what works well and where there are issues – see Appendix B;
   c. assessing the outcomes of a CPD discussion document and related discussions on assuring continuing fitness to practise with stakeholders – see Appendix C; and
considering the developments being made by other UK healthcare professional regulators in developing approaches to assuring their registrants’ continuing fitness to practise – see Appendix D.

4. In January 2015, the Education Committee met in workshop session to consider the outcomes that had emerged from the work programme and to consider the way forward. The Committee noted that:

a. the market research had been useful in scoping out the size and nature of the CPD provision that is available to UK chiropractors and in identifying issues with the provision as well as with registrants’ understanding of how to make best use of CPD;

b. within the current CPD scheme it was noted that:
   i. there is a lack of clarity as to the role and purpose of asking registrants to classify their CPD as relating to improving patient care or developing the profession;
   ii. whilst some registrants still struggle with the concept of a learning cycle or complete it retrospectively, other registrants see it as a useful approach to learning (other regulators also use the learning cycle approach);
   iii. there is a need to improve the way in which registrants are asked to record their CPD so that the recording undertaken for the GCC is of greater benefit to the individual, seen as less of a bureaucratic burden and is more intuitive for individuals;
   iv. there would be benefit if the GCC offered further guidance and support for registrants so that they could better understand what is recognised to be good practice in CPD and how this can enable them to remain fit to practise; and
   v. there is a need to improve how the GCC audits CPD and monitors compliance, including looking across CPD years as well as within CPD years.

c. in looking at how other healthcare professional regulators are taking forward CPD and assuring registrants’ continuing fitness to practise the following trends were identified:
   i. the term ‘assuring continuing fitness to practise’ is now widely used replacing the earlier focus on revalidation (with some regulators specifically stating that revalidation is only one means of providing such assurance and that not a method they wish to use);
   ii. only the General Optical Council uses a system of accrediting CPD providers / provision;
   iii. seeing practitioners as being best placed to identify their own learning needs and how those learning needs should best be met;

1 The Office has already noted and begun a process of acting on the need to improve the approach it uses to audit CPD.
iv. emphasising the need for registrants to be actively engaged, with the opposite (i.e. non-engagement or obstructiveness) recognised as a cause for concern;

v. the use of involving a form of formative feedback from a third party (e.g. patients, other professionals, through audit) on a registrant’s practice or learning and development;

vi. requiring or recommending that learning and development should take place in specific areas of practice which are proving/might be problematic for the profession as a whole;

vii. emphasising the need to develop a culture of professional learning and patient safety;

viii. there are variations in the ways in which regulators use their standards of conduct and competence in assuring continuing fitness to practise, but this tends to be done at a broad level of description not against specific, individual statements; and

ix. regulators are tending to set annual as well as broader time frame requirements in relation to assuring continuing fitness to practise (either by introducing annual requirements if they already work on a 3-5 year time frame or by adding on longer than annual requirements where an annual time frame is used) to emphasise the need for learning and development to be undertaken on a regular basis whilst accommodating specific activities across a longer cycle.

5. The Government in its January 2015 response to the Law Commission’s proposal on the Regulation of Health Care Professionals stated:

“because of the differing nature and size of each profession, the Government believes a one-size-fits-all approach assuring the continued fitness to practise is not appropriate. Regulatory bodies need flexibility around how they seek assurance of the ongoing fitness to practise of their registrants and the type and level of evidence needed to achieve this. Our proposed approach to a future Government Bill is to impose a duty on each regulatory body to seek assurance of the continued fitness to practise of their registrants and to give regulatory bodies the flexibility to develop their own models to discharge this obligation that are proportionate to the risks associated with their professions. … The models being developed by the regulatory bodies share the underlying principles of the GMC medical revalidation process but are based, in the main, around registrants providing assurance they are meeting the standards set in their respective professional codes, in particular standards of continued professional development.” (paras 4.25 – 4.26)²

6. The Education Committee at its January 2015 workshop specifically considered the following:

a how the CPD scheme might be developed to better assure the continuing fitness of chiropractors;

b what actions could be taken in the short term within the current CPD Rules and what would require legislative change – see Appendix E; and

c a proposed plan of work for developing the CPD scheme to assure the continuing fitness to practise of registrants.

7. The outcomes of the Committee’s discussion have been fed into the recommendations below.

Recommendations

8. In the light of all the work that has been undertaken and in the context of the Government’s response to the Law Commission, the Education Committee recommends that a new CPD scheme is designed to provide assurance of chiropractors’ fitness to practise.

9. The Committee recommends the new CPD scheme should be based on the following principles

a retain an annual cycle which requires 30 hours of learning of which at least 15 hours is learning with others – this amount is acceptable to the profession and broadly in line with other professions

b retain the use of learning cycles as the basis of planning, undertaking and reflecting on learning – whilst some registrants still struggle with applying the learning cycle, it is routinely used across other regulators and the GCC could improve the guidance and support it gives to registrants on this subject

c remove the requirement for the learning to be categorised as ‘improving patient care’ or ‘developing the profession’ – various strands of work have indicated that this categorisation is considered to be confusing; responses to the discussion document agree for the categorisation to be dispensed with. This can be achieved within the current Rules.

d introduce requirements to take place across a three year cycle which would count against the hours requirements for those three years (90 hours in total) of:

i. an objective activity (e.g. a case based discussion, peer observation and feedback, patient feedback or clinical audit) – this could build, for example, on the tools already developed by the Royal College of Chiropractors and would be asking registrants to gain feedback from other sources on what they are doing. The feedback is for the registrant to apply in their further learning and development, not for the GCC or others to assess.

ii. a CPD activity in an area identified by the GCC as of importance to the profession as a whole. This might change over time (e.g. from persistent issues in fitness to practise cases or where, for example, new legislation has been introduced). – This would provide a focus for
a small number of the CPD hours in a 3 year cycle (e.g. 2 -3 hours) and be a means of the GCC indicating to registrants areas they need to consider as well as demonstrating that the GCC is responding to and monitoring areas of concern.

iii. a peer discussion to demonstrate engagement with learning and development and reflective practice – the aim of this would be to support registrants in reflecting on their learning and development and applying it to their practice.

e retain a system of annual sampling and audit – this will need further thought in the light of the planned work on improving sampling and audit of the current scheme and the actual developments that take place.

f improve the online CPD system so that it makes best use of up-to-date ICT – so that registrants have the best means available for recording and planning their CPD and the GCC has the best means possible for administering the system.

g the overall approach to be one that is formative and supportive enabling registrants to change their behaviour in the interests of patients – this would include providing generic feedback to the profession as well as possibly commissioning specific provision for supporting reflective practice and the application of learning cycles.

10. The Committee recommended that further thought should be given as to any requirements to link CPD to the Code of Practice and Standard of Proficiency once the Council had approved the new Code. If such linkage was taken forward, it would need to be in relation to broad areas/Principles of the Code and not on a standard by standard basis.

11. The Education Committee recognises that further development is needed on developing each of the above principles into a fully worked up new CPD scheme that offers assurance of registrants’ continuing fitness to practise.

12. A proposed work plan is recommended in table 1.

*Table 1: Proposed plan of work for developing the CPD scheme to assure the continuing fitness to practise of registrants*

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2015</td>
<td>Seek agreement of Council on the way forward</td>
</tr>
<tr>
<td></td>
<td>Start to research and develop the auditing process of current scheme to</td>
</tr>
<tr>
<td></td>
<td>ensure consistency of approach</td>
</tr>
<tr>
<td></td>
<td>Seek legal advice on the interpretation of the CPD Rules and interim</td>
</tr>
<tr>
<td></td>
<td>steps</td>
</tr>
<tr>
<td>April – June</td>
<td>Complete research, development and improvement of auditing process of</td>
</tr>
<tr>
<td>2015</td>
<td>current scheme to ensure</td>
</tr>
<tr>
<td></td>
<td>consistency of approach</td>
</tr>
<tr>
<td></td>
<td>Set up 3-4 development groups of chiropractors across the UK to work</td>
</tr>
<tr>
<td></td>
<td>with the GCC on:</td>
</tr>
<tr>
<td></td>
<td>• Producing good practice guidance and</td>
</tr>
<tr>
<td>Date</td>
<td>Activity</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>examples for current scheme</td>
</tr>
<tr>
<td></td>
<td>• developing the detail of a new CPD scheme</td>
</tr>
<tr>
<td></td>
<td>Refine guidance on current CPD scheme deleting reference to categories of learning and making recommendations on what else registrants might like to do (i.e. proposed elements of new revised scheme)</td>
</tr>
<tr>
<td></td>
<td>Produce exemplars of good practice using 2014 100% audit of CPD as basis of identification</td>
</tr>
<tr>
<td></td>
<td>Research ICT systems for CPD that improve processes for registrants and the office</td>
</tr>
<tr>
<td>July 2015</td>
<td>Education Committee meeting – consider and agree revised guidance on CPD</td>
</tr>
<tr>
<td></td>
<td>Issue revised guidance to registrants for the 2015-2016 CPD year</td>
</tr>
<tr>
<td>August – December 2015</td>
<td>Start process of working with new Government administration to plan when it might be possible to develop new CPD Rules</td>
</tr>
<tr>
<td></td>
<td>Continue development of details of new CPD scheme working with UK development groups of chiropractors</td>
</tr>
<tr>
<td></td>
<td>Produce investment plan for Council on new ICT CPD system</td>
</tr>
<tr>
<td>2016</td>
<td>Consult with the profession and other stakeholders on the proposed revised scheme and draft revised CPD Rules</td>
</tr>
<tr>
<td>2017 – 2018</td>
<td>Implement new CPD scheme (subject to legislative change)</td>
</tr>
<tr>
<td>2018 onwards</td>
<td>Evaluation of revised scheme and further development activity where necessary</td>
</tr>
</tbody>
</table>

**Equality and diversity**

15 Equality and diversity issues will need to be addressed during the course of the development of CPD scheme.

**Communications**

16 The GCC continues to be proactive in engaging with stakeholders to ensure accurate and information is disseminated in relation to CPD and how it will provide assurance of continuing fitness to practise.
Resourcing

17 There are resource implications in relation to:

a developing a new CPD scheme that assures the continuing fitness to practise of registrants –This is, however, a requirement of Government and of the PSA. The costs will be reduced by partnership working with the other healthcare professional regulators as well as with communities of registrants to help ensure that what is developed will work for all stakeholders; and

b researching and commissioning a specific ICT solution – The costs can be reduced by working in partnership with one or more of the other healthcare professional regulators. An improved ICT system will also lead to reduced time in the future for the office and for registrants as it will be possible to make use of a number of automated facilities including automated feedback and one that is compatible with smartphones, tablets and computers.

18 We have a ring-fenced grant from the Department of Health of £72,000 that will be used for this work. When additional significant costs have been identified then Council will be informed.

Action required

19 The Council is asked to agree to the development of the new CPD scheme so that it will offer assurance of the continuing fitness to practise of registrants as set out in the above work programme.

Contact

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Appendix A CPD Market Research Report

Executive summary

Purpose of the project
1. There were four objectives for the project: to provide an assessment of the size of the CPD industry and associated definition; to categorise and quantify the types of CPD providers and provision in the UK; to provide an estimate of the proportion of CPD that is delivered or controlled by GCC registrants; and to provide an accompanying narrative describing the CPD industry.

Main findings about providers
2. The long list of 384 providers named by chiropractors was classified into ten different types:
   a) Entrepreneurial businesses – dedicated to providing CPD (17%)
   b) Professional associations or societies – representing practitioners or interests (15%)
   c) Colleges, universities and schools – providing CPD alongside qualifications (13%)
   d) Well-established clinics or practices – offering CPD as a side line (13%)
   e) Charismatic experts – sharing their knowledge and skills (10%)
   f) Manufacturers or distributors – offering CPD about their products (9%)
   g) NHS or private hospitals and clinicians – briefing about treatments (8%)
   h) Vocational training organisations – providing health and safety courses (7%)
   i) Business training organisations – supporting business development (2%)
   j) Other – not otherwise classifiable (7%)

3. The majority of the named 384 CPD providers are based in the UK though a significant proportion of providers are based overseas, some offering either face-to-face or virtual CPD. At least 89 (23%) are run by chiropractors for chiropractors, of which only 21 (5.5%) are UK based.

4. The majority of providers identified and sampled were in the south of England with many fewer in the north of England, Northern Ireland, Scotland, and Wales.

5. The most commonly used providers cited in the questionnaire are the chiropractic professional associations, the Royal College of Chiropractors (RCC) and the main education providers.

6. The CPD market is mature with the majority of providers sampled having traded for more than 10 years.

7. There is evidence from the sample that the CPD market has grown over the last three years and providers are optimistic about future expansion.

8. Focus group findings suggest that most chiropractors do not have a set budget and spend on average about £1,330 per year on CPD.

9. A large majority of CPD providers sampled offer CPD events as a commercial enterprise and aim to price their events to make a profit or at least cover costs.

10. The typical prices for CPD activities from our sample and focus groups are on average:
   - £40 for a 2hr lecture, £135 for a one-day seminar (most seminars last for 1.5 or 2 days and are priced accordingly). Conferences are charged at on average £125.

11. Sample evidence indicates that a typical provider will hold approximately 6 to 12 events each year. A small proportion of CPD providers interviewed hold more than 50 events per year, the majority hold less than 20.

12. The large majority of providers sampled turn over less than £83,000 from CPD events (i.e. under the VAT threshold).

13. The majority of CPD events sampled are targeted at qualified musculoskeletal professionals, such as chiropractors, osteopaths, physiotherapists and other manual therapists. However, a significant number are targeted solely at chiropractors or at both chiropractors and osteopaths.
14. The large majority of CPD events sampled combine theory with hands on practical activity. About one quarter of providers offer online learning events (e.g. webinars, podcast lectures or coaching).

15. Most CPD providers sampled claim a national or international reach for events. Providers typically offer events in 2 or 3 locations with a minority offering them round the country.

16. The majority of CPD events focus on techniques or medical and health related topics, the least common content was on improving clinic or practice management and briefings on products. Chiropractors confirm that it is more difficult to find CPD on business or practice management.

17. Providers interviewed suggest that the most common external influences on the design of CPD programmes were: views of delegates; strategic partnerships; developments in MSK health; and their internal organisational policies.

18. Providers identified the most common practical factors influencing the design of their CPD programmes as: the number of delegates; scheduling factors; the location and venue; and choice of topic.

19. Based on the 15 interviews with providers, it is likely that a minority of CPD includes active support for reflective practice beyond the completion of a feedback form.

20. All CPD providers interviewed would be responsive to developments from the GCC with a majority being able to change their CPD programme as necessary within less than 6 months.

21. The sample shows that the vast majority of face-to-face CPD events offer a record of attendance. The systems for verifying online learning are less clear. The minority, typically educational providers (usually universities, vocational training providers and colleges), may offer some CPD that is formally assessed and includes a certificate of achievement.

22. Quality assurance processes vary across the sample in terms of robustness. The most common method is the delegate evaluation form, followed by reliance on the reputation of the speaker. Educational providers usually have a formal internal quality assurance system that is often supplemented by external oversight (e.g. from an awarding body, sister organisation or outside agency).

23. Providers suggest that more could be done by the GCC, RCC and the main education providers: to support the development of chiropractor’s skills in communicating with patients; and other essential skills associated with running a successful practice that meets patient’s needs.

Main messages from chiropractors

24. Chiropractors are mainly reactive to marketing materials, with few seeking out information. Mailing lists, professional association websites and word of mouth are most commonly referenced sources of information.

25. The most relevant factors for chiropractors when choosing CPD are: relevance or interest; the reputation of the speaker or provider; distance of travel; and cost.

26. Chiropractors raised issues about marketing at the focus groups, such as: the lack of provision in the north of England; unsympathetic scheduling; poor or last minute publicity; and lack of clarity costs (e.g. not knowing when CPD was subsidised).

27. Chiropractors find seminars/master classes the most useful, then courses and peer group discussions as the next most useful. The least useful delivery method is via exhibitions.

28. Online learning has mixed reviews. Some chiropractors welcome the ease of access to online learning methods, but prefer activities where they can interact and share ideas with others.
29. Chiropractors report that **effective CPD events** are characterised by: their relevance; applicability; currency; structure; practical element; inspirational nature; and follow up offer.

30. Chiropractors report that **poor quality CPD**: is poorly organised; poorly communicated; includes out of date content; ignores their learning needs; has an inappropriate approach; and lacks learning support materials.

**Key themes and recommendations**

31. Some chiropractors have **difficulty in accessing affordable and local CPD**, particularly in the North of England and Northern Ireland.

32. Self-initiated **local learning hubs** have been set up, which could be supported by the GCC and associations.

33. Chiropractors value local networks but would benefit from GCC being clearer about the **value and balance** of formal and informal 'learning with others'.

34. Chiropractors are unclear about whether online learning 'counts' and would welcome additional guidance on the applicability of **online learning options**.

35. Verifiable interactive online learning could help chiropractors to access affordable CPD, particularly in areas that are currently poorly served. The main providers and associations could do more to **diversify their delivery methods**.

36. The research has found different motivations and reasons that chiropractors have for the CPD they do, which if **shared with providers** could better inform marketing and promotion of CPD.

37. Chiropractors seem not to be aware of the wide range of CPD opportunities. The GCC and other key players could usefully explore ways to support the **online marketing by providers**.

38. Both chiropractors and providers suggested the possibility of the GCC **hosting a ‘virtual space’** where registrants could find out about the wide range of CPD available to them.

39. The associations could use online methods to support members or local hubs to find ways to **keep in touch with providers** to better keep up to date with what’s on.

40. **GCC approval or kite marking** of CPD events or providers had a mixed response and could benefit from further exploration with registrants and CPD providers.

41. Chiropractors seem to think the GCC views some types of CPD positively and some negatively. Any confusion could be reduced through better communication of the GCC’s **ethos and values**.

42. The research has elicited **comments on the current CPD system**, which the GCC are encouraged to view as a source of valuable feedback when considering any future revisions.

43. Providers contacted for the research were responsive to the GCC, prepared to adapt their CPD offer and seem open to **making links with the GCC** to better support the chiropractic profession.

44. Providers seem interested in being updated about any changes that may affect chiropractic CPD, which will rely on the GCC developing appropriate targeted **methods of communication**.
Appendix B: Summary of the issues identified with the current CPD scheme

1 Over the last few years the GCC has undertaken a number of activities to assess the extent to which the current CPD scheme is understood and usable by registrants. These include:
   a a 100% audit of CPD returns in 2014
   b a qualitative analysis of CPD learning cycles undertaken by the Royal College of Chiropractors in 2012 (following a number of quantitative CPD reports they had carried out on learning activities)
   c an online questionnaire to registrants about current CPD scheme 2012.

The 2014 audit

2 In 2014 the Registration Department of the GCC undertook a 100% audit of CPD returns (a full audit has always been signalled as a possible approach by the GCC although this is the first time it has occurred). The most common issues that were identified in the audit were related to:
   a the recording / reporting of learning cycles – lack of specificity, using the broad aims of CPD as learning needs, using learning activities as learning needs
   b learning activities and their categorisation into improving patient care or developing the profession – business related CPD, networking, spinal screenings, animal chiropractic, social media, teaching
   c the audit of CPD returns – limitations with the evidence offered by registrants, registrants not understanding why they should not be submitting the same CPD returns each year, registrants asking why a seminar was accepted for one person but not another.

3 The audit revealed that a number of improvements could be made to GCC systems such as:
   a where and how CPD documentation is held and stored in the organisation
   b tracking amendments on CPD documentation and records
   c lack of synchronisation between e-form and paper form
   d tracking repeated CPD
   e informing registrants about how the office checks and audits CPD
   f providing and continuing to provide guidance on CPD
   g improving the e-CPD system.

RCC qualitative analysis

4 In 2012, a qualitative analysis of CPD learning cycles undertaken by the Royal College of Chiropractors concluded that registrants:
   a appear to have difficulty determining whether their CPD relates to improving patient care and/or developing the profession
b appear to document learning needs / interests after the learning has taken place rather than to plan the learning they intend to undertake

c appeared unclear about the purpose of evaluating learning or how to undertake this

d generally indicate the value of their learning to changes in, or confirmation of, their practice.

5 The College offered a number of recommendations to improving the current scheme such as modifying sections of the current form to focus registrants' responses and improving the online system.

Online questionnaire to registrants about current CPD scheme 2012

6 Also in 2012, 465 registrants (16.9% of the registrant base at the time) completed an online questionnaire about the current CPD scheme. 94% of respondents were on the practising register. These questionnaire responses showed that:

a whilst respondents state they are generally clear / understand what they need to do in the CPD scheme they do not always understand the need for doing it or agree that it should be done

b a number of respondents undertake learning and then complete the learning cycle retrospectively

c the majority of respondents to the questionnaire state they are clear about the distinction between categorising their CPD as either focused on improving patient care or developing the profession. However the RCC’s analysis showed this appeared to often be done inconsistently and recommendations for change from registrants suggest that there is a lack of clarity as to the meaning of the term ‘developing the profession’. In addition some registrants feel that everything should be capable of being tracked back to improving patient care.

d overall there appears to be a recognition that learning with others adds value to individual’s learning although there is less agreement as to whether CPD recording should only focus on this

e respondents have mixed feelings on the value of having a minimum number of CPD hours to undertake each year recognising that it is an easy way to measure CPD but that hours do not reflect the quality of the learning experience

f there are mixed views on the value of recording ‘learning on one’s own’ and also the best ways of doing this

g a number of comments suggest that registrants see the value in doing CPD but not recording various aspects of it (eg planning learning, evaluating learning, describing how learning has been applied to practice)

h 71% of respondents stated they use the online CPD system and 44% reported it as very straightforward to use

i of the 29% of respondents who stated they did not use the online CPD system the majority reported that this was because they preferred to ‘stick to a paper-based recording system’ for their learning or had tried the
system but found it difficult.

7 In relation to the changes that respondents would like to see in the future:
   a 26% stated they would prefer not to record the learning cycle
   b less than 30% would like to see any of the changes proposed in the
      previous consultation on revalidation (ie integrating audit into CPD,
      introducing mandatory subjects in to CPD, or introducing mandatory forms
      of learning and/or assessment).

8 Overall a significant proportion of those who responded to the questionnaire felt
   that the CPD system that was currently in use worked pretty well as it was and
   would rather it remained as it was or only tweaked slightly.

Information on the current scheme

9 Taking the information gained from these three reports, the findings reveal:
   a issues with asking registrants to state if their CPD relates to improving
      patient care and/or developing the profession
   b a number of registrants find it difficult to understand and/or apply the
      learning cycle approach or do not really wish to engage with it
   c a number of registrants undertake learning and then complete the learning
      cycle retrospectively
   d a lack of clarity about CPD being related to the learning and development
      of the individual registrant so that they remain fit to practise (some tend to
      see CPD as anything which they do not count as ‘their normal work’)
   e registrants appearing unclear about the purpose of evaluating learning or
      how to undertake this
   f possible issues with how the GCC currently asks registrants to record
      their CPD
   g the possibility of improving the online system or making it one that is more
      capable of meeting both registrants’ and the office’s needs in auditing
      CPD
   h issues with how the GCC currently monitors the CPD that individuals
      undertake across years as well as within years (including evidence that
      potentially some registrants are submitting the same information on their
      learning each year)
   i issues with registrants not engaging with the purpose and value of CPD
      rather seeing it as an administrative hoop through which they need to
      jump to continue to practise.

10 The office has also identified the need to undertake more work on how it can best
    audit CPD and has initiated work into investigating the processes used by other
    regulators and how learning can be applied in GCC processes. This will be
    undertaken from February 2015 and completed in time for use in auditing the
    next round of CPD submissions.
Appendix C: Overview of responses to the CPD discussion document 2014

1 The CPD discussion document, approved by the Education Committee at its May 2014 meeting, was non-directive and discursive and included information on issues with the current CPD system and possible ways forward for assuring the continuing fitness to practise of chiropractors in the UK1. The areas explored in the discussion document were:
   a The principles that should inform our approach to CPD
   b The purpose and aims of CPD
   c The effectiveness of CPD
   d Professional Learning – Learning Cycles and Reflective Practice
   e Content of CPD
   f The length of time in practice
   g The amount of CPD
   h The nature of the learning undertaken
   i The CPD cycle – its length and nature
   j Assessing an individual’s CPD
   k Quality assuring CPD
   l Registrant engagement
   m Evidence of CPD.

2 The consultation on the CPD Discussion Document initially ran from 18th June to 15th August. As only nine written responses were received in this time period the GCC reissued the document in October 2014 and extended the deadline until 21 November 2014 encouraging more individuals and organisations to respond.

3 By the end of November 2014, 30 responses had been received. The respondents were as shown in table 1:

- Table 1: respondents to the CPD discussion document 2014 by type and number

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractors</td>
<td></td>
</tr>
<tr>
<td>Practising</td>
<td>24</td>
</tr>
<tr>
<td>Non-practising</td>
<td>1</td>
</tr>
<tr>
<td>Anonymous</td>
<td>1</td>
</tr>
<tr>
<td>Professional organisations</td>
<td>4</td>
</tr>
<tr>
<td>Educational providers</td>
<td>-</td>
</tr>
<tr>
<td>Patients and the public</td>
<td>-</td>
</tr>
<tr>
<td>Total responses</td>
<td>30</td>
</tr>
</tbody>
</table>

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4 The professional organisations that responded were: the BCA, the RCC, the SCA and the UCA. There was no response from the McTimoney Chiropractic Association (MCA) nor from patient or public organisations or individual patients.

5 Responses varied in format and level of detail. The detailed responses were collated using a spreadsheet. Table 2 sets out the number of responses received for each question and who the number and type of respondent. It shows that different areas of the discussion document stimulated different amounts of feedback, although this needs to be taken in the context that some of this feedback consisted of one word answers, such as 'no' when people disagreed with a statement.

6 Due to the discursive nature of the document and its intention to promote discussion, it is not possible to provide a quantitative analysis of the responses.
### Table 2: Number of responses received to each question in the 2014 CPD discussion document and the respondents to each question

<table>
<thead>
<tr>
<th>Question (in brief)</th>
<th>Total number of respondents</th>
<th>Chiropractors – practising</th>
<th>Chiropractor – non-practising</th>
<th>Professional organisations</th>
<th>Anonymous</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Principles to inform our approach</td>
<td>10</td>
<td>6</td>
<td>-</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>2. Aims of CPD for individual chiropractors</td>
<td>11</td>
<td>7</td>
<td>-</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>3. Aims of CPD for the system</td>
<td>9</td>
<td>6</td>
<td>-</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>4. How emphasise learning &amp; development</td>
<td>13</td>
<td>9</td>
<td>-</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>5. Literature on effectiveness of CPD</td>
<td>7</td>
<td>3</td>
<td>-</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>6. What CPD do you find effective?</td>
<td>11</td>
<td>9</td>
<td>-</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>7. Retain learning cycles</td>
<td>15</td>
<td>11</td>
<td>-</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>8. Benefits of reporting on learning cycles</td>
<td>16</td>
<td>11</td>
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<td>9. Drawbacks of reporting on learning cycles</td>
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<td>10. GCC to stimulate provision on learning cycles?</td>
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<td>11. Support on reflective practice?</td>
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<td>12. Get rid of the two categories of improving patient care &amp; developing the profession?</td>
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<td>13. Benefits of relating learning to CoP &amp; SoP?</td>
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<td>14. Drawbacks of relating learning to CoP &amp; SoP?</td>
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<td>15. Benefits and drawbacks of CPD in specific areas</td>
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<td>16. Any advantages in setting topics for CPD?</td>
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<td>18. How best to link CPD to FtP cases?</td>
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<td>years in practice?</td>
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<td>20. Changing CPD in relation to employment roles?</td>
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<td>21. Specific CPD requirements for new registrants?</td>
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<td>22. Differences between new UK graduates and registrants from overseas?</td>
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<td>23. Change 30 hours per year minimum requirement?</td>
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<td>24. Do you need an hours requirement?</td>
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<td>25. Tighten learning with others?</td>
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<td>26. How improve learning with others?</td>
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<td>27. Replace learning with others with QA peer review?</td>
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<td>28. Retain annual cycle?</td>
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<td>29. Some elements of CPD over more than a year?</td>
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<td>30. A longer CPD cycle with some annual monitoring?</td>
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<td>9</td>
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<td>32. Peer review?</td>
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<td>33. Approve providers of CPD?</td>
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<td>34. If wish to approve providers, how?</td>
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<td>35. How else could GCC assure CPD quality?</td>
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<td>36. How enhance CPD to enable chiropractors to see its value?</td>
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<td>37. What do with obstructive chiropractors or those who do not engage?</td>
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<td>38. What evidence to the GCC?</td>
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<td>39. Higher evidence requirements if had</td>
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<td>had FtP case?</td>
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<td>40. How best obtain evidence?</td>
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<td>42. CPD applicable to all?</td>
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<td>43. Equality issues?</td>
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<td>44. Anything else?</td>
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Overall findings

7 Overall whilst the response rate to the discussion document was fairly low, even after further time and encouragement was given, the responses that were received were well considered and focused on the discussion that was presented.

8 The feedback received suggests that there is broad support for:
   a the current system of CPD
   b the principles, purpose and aims of CPD
   c learning cycles
   d removing the two categories of ‘improving patient care’ and ‘developing the profession’ against which CPD activity currently needs to be reported
   e retention of an annual CPD cycle
   f the current hours requirement of a minimum of 30 hours

9 There appears to be broad agreement that:
   a there is need for further guidance and support from the GCC in a number of areas (such as learning cycles)
   b there would be value in the GCC offering examples of good practice in CPD (eg in the form of case studies)
   c there would be benefits in the GCC commissioning / stimulating some CPD provision (eg to enable chiropractors to use the learning cycle approach more effectively, areas where there are a pattern of fitness to practise issues)
   d ‘learning with others’ is helpful but interpretation of how this takes place should be broadened
   e there is no value in approving providers of CPD

10 There are mixed views about:
   a introducing an element of quality assured peer review and how this could be implemented
   b the value of incorporating patient and colleague feedback into CPD
   c the actions that should be taken with chiropractors who are unnecessarily obstructive or do not engage, with some seeing this as a clear fitness to practise issue whereas others suggest a more facilitative approach (or at least initially)
   d whether there should be higher CPD evidence requirements placed on those who have had a fitness to practise case upheld.

11 There appears to be no real support for:
   a asking chiropractors to report their CPD activity against the CoP and SoP due to the perceived complexity of the process
   b changing CPD requirements based on the number of years an individual is in practice or in relation to their role / employment
   c approving CPD providers or events.
12 Some respondents proposed that:
   a there should be specific principles for CPD in addition to right touch regulation principles
   b chiropractors should be asked to justify each individual CPD activity in terms of how it benefits patient care
   c an online learning portfolio would benefit chiropractors, aid reflection and assist in the submission of the CPD record
   d evidence is emerging that informal learning with peers is more important than structured learning
   e setting CPD subjects might help clarify the relevance of CPD activity for chiropractors
   f the PRT system should be made compulsory for new graduates in their first year of practice.

13 There was some indication (from the discussion document and separate conversations that GCC officers have held with the professional organisations) about how 'acceptable CPD' is being interpreted and the implications of this for any future developments. This relates to the content of CPD that is accepted by the GCC and the extent to which it needs to relate to the CoP and SoP as well as distinguishing between those aspects of professional life which should rightly have a focus (such as running an effective practice which meets the needs of patients) and those which might be seen as more dubious (such as practice building seminars).

14 In summary, it appears that issuing a discussion document about the current CPD system and possible ways of developing it has been a useful exercise in setting out the GCC’s thinking on how it might move forward. It has been disappointing that there was no response from the MCA or patient and public groups and few responses from chiropractors. However the responses that have been received indicate where there might be support for changing the CPD scheme in a number of ways to address current issues and also give greater focus on it assuring the continuing fitness to practise of chiropractors.
The feedback received to each area and question in the discussion document is summarised below.

Principles of CPD

The four professional organisations and the 6 chiropractors who responded to this question (Q1) were broadly in agreement that the PSA’s principles of right-touch regulation (2010) were the appropriate principles to inform the approach to developing the CPD system (ie proportionate, consistent, targeted, transparent, accountable, agile).

One chiropractor noted accountability should be towards the chiropractor too. The Royal College of Chiropractors (RCC) noted that these are general regulatory principles and not specific to CPD. Another gave a detailed explanation as to the benefits as they saw it of the GCC commissioning specific seminars and the need for effective communication.

The RCC proposes that as CPD is about the professional development of practitioners undertaken in the interests of patients, “its key principles are that it is positive, professionally holistic and self-directed in the interests of the practitioner and the GCC should facilitate this”.

The purpose and aims of CPD

Q2 Are the aims of CPD for individual chiropractors the right ones? If not, what aims should be included?

Four professional organisations and 7 chiropractors responded to this question.

The SCA and UCA agreed that these were the right principles for individual chiropractors noting that: “registrants have different learning needs at different stages of their professional life”.

The BCA drew attention to “critically appraising and reflecting upon practise” as also being a worthy aim for individual chiropractors (and referenced para 27 in the document).

The RCC added the following aspects to the aims for chiropractors:

- identifying and addressing gaps in knowledge
- engaging and learning with others in a learning context.

Five of the seven chiropractors who responded stated that the aims were correct for individual chiropractors. One commented that aims (b) and (c)2 were rather normative and chiropractors should not be forced “to take an interest in those broader aspects listed, or being forced into the mindset that we’re never good enough and always could do better”. Another chiropractor explained how learning needs change through one’s development as a practitioner and the learning they found most helpful for them currently.

Q3 Are the aims for the CPD system the right ones? If not, what aims should be included?

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2 Aim (b) keep up-to-date with chiropractic and healthcare practice, the expectations of their patients and the broader healthcare and regulatory context; and aim (c) “continually improve what they do”. 
Three professional organisations and 6 chiropractors responded to this question.

The SCA and the UCA stated the aims were correct for the CPD system as “a conscientious chiropractor will carry on developing him/herself over time by attending the courses/meetings/workshops that are most beneficial to them in meeting these aims”.

The RCC stated that: “The stated aims for the system are reasonable, although they begin to go beyond the definition of CPD and into continuing fitness to practice. It is important to recognise that there will always be trade-offs when attempting to ensure positive professional development and assure fitness to practise when using the process of CPD to achieve both”.

3 of the 6 chiropractors agreed that the aims for the system were correct. The same chiropractor (as for Q2) felt the “normative emphasis on improvement” was unnecessary, one found some of the aims confusing (particularly aim (b) enable chiropractors to critically appraise their practice, reflect on how they can develop and understand the limits of their competence). One chiropractor reflected on each aim separately and compared this to how they currently practise and undertake CPD, overall apparently concluding that the aims were broadly right although often difficult to measure.

Q4 How can we emphasise to chiropractors that CPD is about learning and development not about other activities they undertake?

Four professional organisations and 9 chiropractors responded to this question.

All four of the professional organisations stated that registrants do understand that CPD is about learning and development.

The BCA stated: “Most chiropractors implicitly understand that learning and development is a key element to professional practise. The average number of hours engaged in such activity is evidenced of this. There should be little concern that they do not see recording such learning as importantly as the GCC. However, the majority leave completion of the PDP to the last minute and there needs to be a culture instilled in chiropractors that the process should be on-going and in that way will require the minimum of effort. An online portfolio record of learning may benefit chiropractors, aid reflection and assist in completion of the CPD submission at the end of the cycle.”

The SCA and the UCA both stated: “In general terms it is clear to registrants that learning and development activities are key to CPD”. Both argued that another key aspect is the learning and development that registrants undertake to “develop themselves and their businesses to improve their patients’ experiences and health”. The SCA stated it did not agree that “chiropractors have simplistic view that CPD is just about ‘other activities’ they undertake” and that perhaps “the idea of planning a learning cycle a year in advance is flawed”.

The 9 chiropractors who responded to this question agreed with the premise that CPD is about learning and development and either referred to the documents (including this discussion document) in which this is described or suggested that further information should be provided by the GCC about this. It was also suggested that professional associations and the chiropractic education providers might help with this, and one respondent suggested that others should do what they do and contact the GCC if in doubt. However one chiropractor felt that if CPD were to be pegged to the CoP and SoP then this would stifle learning and development and
hence CPD. Finally one queried why running a business was not seen as CPD as it is an area ill-covered in initial training and essential part of running a practice.

The effectiveness of CPD

Q5 Is there other literature showing the effectiveness of CPD that we need to take into account?

Four professional organisations and 3 chiropractors responded to this question all by saying they were not able to provide any information. Similarly the SCA and the UCA stated they were not aware of any literature showing the effectiveness of CPD with the SCA adding this was due to a lack of studies in the area.

The BCA stated there is “some evidence that informal learning from peers is more important than structured learning (eg in lectures)” and suggested a contact at the AECC who could provide more information. It also added some references for further information.

The RCC recommended a further, more recent text and recommended that the GCC send a representative to a December 2014 conference organised by the Professional Associations Research Network (PARN).

Q6 What CPD do you find effective for you and why?

2 professional organisations and 11 chiropractors responded to this question.

The SCA and the UCA both stated that their “membership finds a mixture between working/learning with others and attending seminars as being effective. Each chiropractor will have their own particular preference.” The SCA added that: “Development of the profession is poorly defined e.g partaking on the executive of an association board is not seen as being involved in the development of a profession”.

The 11 chiropractors who responded cited a range of CPD as being most effective for them personally. The different areas noted included:

- workshops and seminars
- peer discussions - with my colleagues and chiropractor friends - discussing difficult cases or seeking advice on never treated before issues - also on patient management
- regular study groups with peers which allow me to develop and share personal experiences and learn from others
- meeting up with other chiropractors for lunch and discussing chiropractic in our local area, trends etc
- courses that:
  - introduce new concepts or extend boundaries and encourage more study
  - refresh and amplify initial training
  - provide a forum to discuss difficult cases
  - are available at reasonably-attainable rates and locations
- reading every day.

Boud, D (1988). Developing student autonomy in learning
Bruner, J (1973) Going Beyond the information given
Perhaps the individuals who responded can best be summed up in this quote:

“what do I find effective, a varied approach depending on my personal development requirements and goals. Reading is on a daily basis, whilst learning with others sparks debates and differing views to be explored. Learning is both opportunistic as well as planned, and therefore development should not be exclusive but inclusive of the evolution of thought and learning.”

Learning cycles and reflective practice

Q7 Do you agree that we should retain learning cycles as the broad approach that should inform how chiropractors undertake their CPD?

Four professional organisations and 11 chiropractors responded to this question.

All four of the professional organisations that responded agreed that learning cycles should be retained (with the BCA simply stating yes). The UCA noted that learning cycles were not specifically included in the GCC’s current CPD Rules but stated the broad components are relevant to adult learning. The SCA noted that “if you have a rigid learning cycle to necessarily find the right course/workshop to attend in that period”. The RCC stated that it has operated a learning cycle approach over a number of years, including pre-dating the GCC’s requirements, and found it manageable. It suggested that: “the GCC should work to highlight and demonstrate the positive benefits to chiropractors of planning, undertaking and evaluating all CPD and make this a requirement. This does not mean that all CPD has to be planned a year in advance, but that new cycles are started as needed thus ensuring evaluation/reflection takes place for all learning”.

There mixed responses from the 11 chiropractors who responded. Some individuals reported learning cycles to be confusing or in the past having done so, or as a chore to be completed. It was felt that the GCC places too much emphasis on the retrospective nature of learning cycles and this does not recognise either the opportunistic nature of CPD nor the practical aspects of programming CPD on an annual basis. Overall the advice from the RCC that the GCC needs to do more work in highlighting the benefits of a learning cycle approach is confirmed by the individual chiropractors’ responses.

Q8 What are the benefits of being required to report on a learning cycle from the perspective of chiropractors, patients and other healthcare professionals?

Four professional organisations, 11 chiropractors and one person who wished to remain anonymous responded to this question.

The SCA and the UCA both stated that “the benefit of a learning cycle is that it provides a both a template and the environment for reflective practice and learning”. The UCA added that they: “agree with the value in personal development planning, self-directed learning and reflection. This framework would seem to instil more confidence in patients that the aims of CPD are being met.” Whereas the SCA added it: “can also become a tick box exercise if the registrant can't find the right courses to match the cycle”.

The BCA stated: “registrants are following a proven method of identifying carrying out and evaluating a learning need” and it “is useful for chiropractors because it makes explicit the thinking that they have gone through identifying their learning needs, even if they are recording this after-the-fact”.

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The RCC stated that the benefits of learning cycles: “largely relate to the value of reflection on the learning experience. Reflection enables the learner to relate and apply their learning to practice in order to gain full benefit and value for money. It helps ensure actual learning – without it potential learning experiences are often forgotten. It also helps identify the need for further learning and improvement.” It reiterated its recommendation that the GCC should enable chiropractors appreciate and understand the benefits of learning cycles to themselves and their patients.

As a group, the 11 chiropractors who responded were less clear of the benefits of the learning cycle approach. Those who could not see the benefits for them as individuals stated:

- there are no benefits
- never having understood the benefits even when an undergraduate
- completing learning cycles after having completed learning so there being no real benefit except for meeting form filling requirements
- learning cycles being a waste of time and effort for chiropractors as learning is only successful if it changes or reinforces practice, probably of no benefit or interest to patients, but desirable for educators and regulators as it provides documentation to show something is being done and formal self-reflection is currently trendy.

Those chiropractors who felt there was benefit in learning cycles reported these benefits as:

- continuing to engage and enable a process of learning
- encouraging reflection on the learning itself and its use and improving the experience provided for patients and hopefully better treatment outcomes
- providing some form of specific review and regulation of what an individual is doing to maintain and improve their skills which is helpful for chiropractors, patients and other healthcare professionals.

One respondent did not comment on the benefits but suggested that the learning cycle approach should be restricted to either only some of the required hours (eg 6 out of the 30 hours per year) or to the ‘learning on own’ part of CPD as this would give that part more structure.

Q9 What are the drawbacks of being required to report on a learning cycle from the perspective of chiropractors, patients and other healthcare professionals?

Four professional organisations and 11 chiropractors responded to this question. One of the chiropractors was non-practising.

The RCC noted that if no work is done by the GCC to enable chiropractors appreciate and understand the benefits of learning cycles then it is likely to be seen as burdensome. It noted that: “some years ago, the RCC developed a CPD reflection form to structure and guide learners reflecting on their learning, and all delegates to RCC events are provided with this. Such tools aid the process”. The BCA response was similar in that it noted that “chiropractors are likely to view recording their learning cycle as bureaucratic” and any ways of reducing this view would be welcomed.

The UCA stated that: “The drawbacks on reporting on a learning cycle are many, but not insurmountable. If the registrant has a particularly rigid learning cycle, then finding the right course/workshop to attend within the time period may prove impractical” and could become “a tick box exercise if the registrant can't find the right
courses to match the cycle”. It suggested that: “guidance might be useful in selecting a broad learning cycle, so that registrants can pragmatically take advantage of the undisputed value of relevant, opportunistic learning situations as they arise”.

Both the UCA and SCA stated that reporting a learning cycle could perhaps “encourage some chiropractors to simply input a cursory report, rather than encouraging deeper reflection”. They stated that: “overall, many patients would not understand the learning cycle, but if CPD became overly complicated and required the chiropractor to take more time out of practice, many patients would be concerned if their chiropractor was less available”.

The chiropractors who responded noted:

- it is not always possible to know what interests you until you discover it by chance as you do not know what you don’t know
- seminars are not available in the time period or not known about sufficiently far in advance
- seminars are not chosen on the basis of learning needs
- chiropractors are unsure they can, or not confident in reporting that they have not met all of their learning needs in the year as they believe this will reflect badly on them in the eyes of the GCC
- learning cycles made CPD more onerous and time-consuming
- learning cycles might be applicable to students but not to professionals who should not held accountable in this way and should be able to decide how they plan and undertake their CPD
- the current format of recording making it difficult to record long and short learning cycles
- the difficulty of evaluating the benefit of courses until they have been attended with some looking good but not being so and others not looking particularly valuable but proving really useful for own development and patient care
- possibly be detrimental to learning as chiropractors might stick with their pre-planned learning cycle and ignore other opportunities.

One chiropractor stated they could see no drawbacks to using a learning cycle approach, while another thought registrants did not understand that the GCC was genuinely interested in finding out if chiropractors could not access some areas of learning and development as they could then do something about it.

**Q10. Would it be beneficial for the GCC to stimulate / commission some CPD provision to enable chiropractors to use the learning cycle approach more effectively?**

Four professional organisations, 10 chiropractors and one person who wished to remain anonymous responded to this question.

The BCA, the UCA and the RCC all noted that there would be benefit in the GCC stimulating / commissioning learning, either materials or events, on the process and benefits of learning cycles. The RCC added that it should be the provider for this and indeed it was its role as a Royal College to assist the regulator in such an activity. The SCA simply stated “yes, dependent on the CPD provision that the GCC may commission and costs”.

The individual who wished to remain anonymous noted that the CPD system should not change and that “chiropractors should be able to choose their learning without the GCC telling us what we should learn and where best to learn from”.

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Of the 10 chiropractors who responded:

- five stated that the GCC should not do this, mainly it seems because they do not wish learning cycles to be used although one stated that chiropractors should be able to read the guidance that is already available
- two saw the value in offering CPD on how to more effectively use the learning cycle approach
- three thought there was value in the GCC commissioning CPD more generally with one noting that this could particularly help registrants in the north.

Q11. Is there other support that could be given to chiropractors in relation to reflective practice? If so, who should provide this support?

Three professional organisations and 8 chiropractors responded to this question.

The SCA and the UCA suggested that perhaps the GCC should run seminars on fitness to practise in which registrants could discuss complaints. The SCA in addition thought: “Care should be taken to identify trends in complaints - an enhanced CPD system based on the FtP trends could suggest planning guidance on CPD”. The BCA suggested that: “the associations and especially the RCC can provide support and training” and “encouragement to use audit tools eg Care Response” and this would help in this process.

Of the 8 chiropractors who responded to this question, one stated they did not know, one that it was not necessary to provide other support and one that this is based on the assumption that individuals find this helpful whereas in reality practitioners are not interested in such provision. The remainder suggested different ways of offering such support including:

- improving teaching at undergraduate level
- individual chiropractors using peer support to help them reflect on practice
- through having annual peer review in the clinical setting
- the GCC having a more public face and working with the RCC and professional associations primarily in education and support, and only after this by enforcement.

The content of CPD

Q12. Do you agree that it would be appropriate to get rid of the categories of ‘improving patient care’ and ‘developing the profession’ and look to find a more useful way of setting the content of registrants’ CPD?

Four professional organisations and 8 chiropractors responded to this question.

All four of the professional organisations that responded (ie the UCA, SCA, RCC and the BCA) agreed that it would be appropriate to get rid of these two categories. The RCC added that they “would like to see an expansion in the number of categories to incorporate areas of professional development that, for example, may not directly benefit patient care but at least have a positive, indirect effect on it. We believe that asking chiropractors to reference all CPD activities to the relevant section of the CoP and SoP could be troublesome⁵. There are sections of the CoP and SoP that are not relevant to CPD, and huge potential for interpretation in other areas. Drawing up a

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⁵ This answer refers to Q13 below.
separate list of sections that would be “valid for CPD” would just add another layer of complexity to the process."

Of the 8 chiropractors who responded, four agreed that it would be appropriate to get rid of the categories, one stated that it would not be appropriate to do so but gave no reasons while the other two made other statements about the small number of fitness to practise cases each year and the need to think about those who primarily teach.

Q13. What are the benefits of asking chiropractors to relate their learning they undertake for CPD against the CoP and SoP as the means of demonstrating its relevance?

Two professional organisations and 6 chiropractors responded to this question.

The SCA noted that “the CoP & SoP is a benchmark for conduct of practice” whereas the BCA stated: “Chiropractors adhering to the standards set out in the CoP and SoP would be acting safely and ethically but this would not necessarily lead to learning and development. One key advantage of this approach would be removing certain categories of learning from CPD e.g. practice building seminars. We recognise however, that some business related training may be helpful”.

Of the 6 chiropractors who commented on this point, one noted that it helps people to stay up-to-date and focused on the standards of practice, and one that it might encourage people to actually read the CoP and SoP. Two stated that they could see no benefits of linking CPD to the CoP and SoP, one noted that some registrants need more help than others in understanding what is relevant to CPD and did not understand those who had used marketing as CPD, and one stated that GOsC ask registrants to explain the relevance to them (and the CoP and SoP might be one prompts).

Q14. What are the drawbacks of asking chiropractors to relate their learning they undertake for CPD against the CoP and SoP?

Three professional organisations and 8 chiropractors responded to this question.

The SCA and the UCA stated that: “whilst the CoP & SoP is a benchmark for conduct of practice it would be very difficult to as registrants to relate their learning and demonstrate this through CPD due to its size (and complexity). It could make the (CPD) process very complicated and convoluted”. The BCA felt that as the CoP and SoP needs to some extent be written using legal language, then “it may be prohibitive in encouraging Chiropractors to relate their CPD directly. Also some aspects of CoP and SoP aren’t relevant to every Chiropractor or the CPD they undertake”.

On the whole, the eight chiropractic respondents thought this would make the CPD process impractical, more bureaucratic, more time consuming and be unwieldy and consequently have a negative impact on the education and training that is undertaken. One suggested that there were other things that should be used to measure effective CPD (although did not state what these were) whilst another proposed that it would be better to provide registrants with clearer guidelines rather than ask for more requirements.

Q15. What are the benefits and drawbacks of requiring chiropractors to undertake CPD in specific areas (such as those which are consistently shown as issues in fitness to practise cases)?

Four professional organisations and 11 chiropractors responded to this question.
The SCA stated that: “it would be of benefit to encourage chiropractors to focus a proportion of their CPD on common Fitness to Practise issues. This would clearly address patient protection and would highlight common ‘mistakes’ or areas that require improvement”.

The UCA stated that: “A broad spectrum of "topics" may be beneficial. This approach would not be dissimilar to other countries where CPD is split into areas, such as: technique, philosophy, business management, communication, and patient safety. This format would encourage chiropractors to undertake a variety of CPD and reassure patients that registrants are maintaining a well-rounded fitness to practise.”

Whilst recognising that making some CPD subjects mandatory is welcomed by some, the BCA however was less convinced. “The benefits of undertaking CPD in specific areas are that the GCC can be sure that registrants have had access to the information provided in the CPD event. It does not meant that the registrant has learnt from the experience of improved practise. It is important to relate learning to learning need and this is an integral part of autonomy in practice and professional behaviour. Specifying, for example that a registrant must not undertake CPD in the same area on to successive cycles may be counter-productive. For instance, if a learning need involves a long course e.g. a postgraduate MSc it would be inconceivable to disallow such activity. We recognise, however, that some see value compulsory training in specific areas.”

The RCC considered the issue alongside coverage of the CoP and SoP. “Requiring chiropractors to cover all broad areas of the CoP and SoP over a given timeframe would be moving too far along the spectrum from self-directed CPD to a prescriptive, all-encompassing assessment of continuing fitness to practice. However, there is scope to ask registrants to participate in CPD activities that have been identified as profession-wide weaknesses or areas of concern (such as those identified by the Williams FTP review). This would be within the “targeted” principle of the PSA’s principles of right-touch regulation. However, it should be recognised that this may not be the best use of CPD for everyone.

Of the 11 chiropractors who responded to this question, five were in favour, four were against, one was undecided and could see both pros and cons, while one made more general comments (ie current CPD does not prove FtP).

Those in favour thought this would be helpful because:

- it would help improve standards (eg communication, record keeping)
- it would possibly reduce the incidence of complaints
- it could be a useful tool for a small proportion of CPD
- it would show the public that the profession was learning from its mistakes
- it would help chiropractors understand issues and apply learning in the broader context of their work (eg data protection)

Those who were against the idea cited the following reasons:

- availability of CPD events
- it would be confining and restrictive and mean the minority were ruling the majority
- it would remove freedom of choice so that chiropractors would not be able to focus on their own learning needs.
Q16. Do you think there are any advantages in setting subjects or topics that should be covered in CPD learning or that would be used to assess whether the learning undertaken is CPD? If so, what are they?

Three professional organisations and 9 chiropractors responded to this question.

The BCA saw the advantage as being that it might help to clarify what is counted as CPD. The SCA noted that “a broad spectrum of ‘topics’ (was) not dissimilar to other countries where CPD is split into areas such as; technique, philosophy, business management, communication, patient safety may be beneficial. This would encourage chiropractors to undertake a variety of CPD”. Whereas the UCA saw both benefits and drawbacks saying: “the drawback about being prescriptive about CPD is that many registrants will object to these constraints and feel it is limiting their scope of practice or their particular learning needs. However, having a spectrum of topics that could suit all different styles of practice could be of benefit”.

Of the 9 chiropractors who commented no-one spoke clearly in favour of doing this.

Of those who were clearly against this, two simply stated ‘no’ whereas others spoke of chiropractic being very individual with registrants having their own interests and special interests and they should be allowed to pursue these. One proposed more leeway in CPD should be offered to those who work in education, one registrant stated that there should be very little prescription although it would be useful to have something on pathologies, and another stated they were undecided.

Q17. What are the benefits and drawbacks about being more prescriptive about the CPD that chiropractors should undertake and linking this to fitness to practise cases?

Four professional organisations and 8 chiropractors, one of whom was non-practising, responded to this question.

All of the professional associations stated that there were both benefits and drawbacks of being more prescriptive about the CPD that chiropractors should undertake and linking this to fitness to practise cases.

The RCC stated “there will always be trade-offs when attempting to ensure positive professional development and assure fitness to practise when using the process of CPD to achieve both. However, introducing a small amount of prescriptive CPD to address area of known risk is of potential benefit to chiropractors as well as patients, professional associations and the GCC.”

The BCA noted: “there are advantages to being more prescriptive linked to FtP as above. Many chiropractors, however, may not have problems with the FtP issues identified and may resent being forced to carry out CPD in an area they know well. This may well lead to disenchantment with the scheme. However, it may be helpful to tackle specific issues such as patient communication, consent, use of patient data, IRMER, behavioural standards where some chiropractors need more guidance and are lacking in judgment.”

On a similar note, the SCA stated “The drawback about being prescriptive about CPD is that many registrants will object to these constraints and feel it is limiting their scope of practice. However, having a spectrum of topics that could suit all different styles of practice could be of benefit.”

The UCA also sees this as potentially beneficial stating: “It would be of benefit to encourage chiropractors to focus a proportion of their CPD on common fitness to practise issues. This practise would clearly address patient protection and would
highlight common "mistakes" or areas that require improvement. Regardless of graduation from a particular educational institution, length of time in practice, new or international/ new to the UK registrant status, this approach would ensure that ALL chiropractors would be held to the same standard. As suggested above, guidance or seminars/ workshops from the GCC would be most relevant and valuable in this regard”.

There were varied responses from the 8 chiropractors who responded, although generally they were not in favour. The reasons given included:

- the current system already being too prescriptive
- the risks of chiropractic being low so there is no need to follow the GMC
- prescription alienating registrants who have their own interests
- individuals would be required to spend time and money on areas that were of no interest and relevance to them
- prescription being okay for initial learning as an undergraduate but not appropriate for professionals.

One chiropractor who was more in favour of having some prescription stated some chiropractors having poor patient handling and communication skills which could be addressed by compulsory seminars, and another thought that as long as this was done in a balanced way allowing for some free choice along with the prescription then there would be some benefits (although these were not stated).

Q18. If you think it is beneficial to link CPD to the themes within fitness to practise cases, how best could this be done?

Three professional organisations and 4 chiropractors responded to this question.

The SCA and the UCA both stated that: “whilst fitness to practise themes could be included within CPD, it would be simpler and probably beneficial for the GCC to host workshops to address common areas of complaint and allow discussion. Perhaps it could be mandatory for a registrant to attend one workshop every 2 years”.

The RCC commented: “It would not be a straightforward task to link some FtP areas, such as enhancing professionalism for example, to prescriptive CPD (the RCC, for example, is addressing the enhancement of professionalism in a range of other ways and this is a long term process). However, other areas, such a poor record keeping, could be readily addressed provided the GCC makes its requirements know well enough in advance to enable providers to respond. A better approach might be for the GCC to commission CPD events/learning material from suitable provider/s”.

Of the four chiropractors who commented, one simply said ‘no’ while two others reiterated earlier points about registrants having different learning needs or their interest in having some prescription around pathologies. The fourth chiropractor suggested that the GCC should: “ask registrants to read and comment on the cases, and allocate two hours of learning-alone CPD for that purpose. That leaved 28 hours of otherwise-unfettered CPD.”

Length of time in practice

Q19. What are the advantages and disadvantages of changing the CPD that registrants need to undertake based on the number of years they have been in practice?

Four professional organisations and 7 chiropractors responded to this question.
The professional organisations felt either that the disadvantages outweighed the advantages or there were no advantages. The UCA and the SCA stated there were no advantages and that it would overcomplicate the system unnecessarily, which would increase costs. The RCC believes that it is difficult to justify except in the case of new graduates and that any differing requirements would add to confusion. The BCA noted that, whilst some recent research suggests that years in practice might have an effect, this might be negated by future research, and like the RCC believe that the only justifiable difference would be those newly into practice.

Of the seven chiropractors who responded, most were against CPD being linked to number of years in practice seeing it as discriminatory, complex and confusing. One noted years in practice is more realistic than age and that BUPA will not recognise practitioners of less than five years standing whilst another stated different requirements would only be acceptable in relation to new graduates.

Q20. What are the advantages and disadvantages of changing the CPD that registrants need to undertake based on the roles they are currently undertaking / are employed in?

Four professional organisations and 4 chiropractors responded to this question and generally could not see the value in changing CPD based on role undertaken.

The RCC stated: “as long as a chiropractor is seeing patients, and wishing to remain on the register, then (for the protection of patients) their CPD requirements should be the same, regardless of the role they are undertaking”.

The BCA stated that: “there is considerable heterogeneity within the chiropractic profession. Registrants themselves are best able to understand their current need. A scheme that specifies a learning requirement may not match the need of a significant number of individuals. It is also likely to be difficult to administer”.

The SCA stated there was no benefit to changing CPD based on a registrant’s role and the disadvantage would be “overcomplicating the system and there may be instances when an individual may change their role a number of times within the reporting year. It would also be very costly and difficult to administer”.

And the UCA stated that: “in theory, a robust, relevant and broad CPD scheme would allow for the changing learning needs throughout a registrant's professional life and all of the many roles a chiropractor might take on”.

The four chiropractors were generally not in favour of this due to CPD interests changing automatically according to roles and employment, roles do not always denote what should be studied and the overall focus should be on improving care for patients and such an action is unnecessary as CPD is already self-directed.

Q21. Do you think that new registrants should have specific CPD requirements to enable them to make the transition to independent practice in the UK? If so, what should these requirements be?

Three professional organisations and 8 chiropractors responded to this question.

The views of the three professional organisations that responded to this question were along similar lines although with a slightly different emphasis. The RCC stating: “there are unique issues for new graduates (essentially due to inexperience and the transition to unsupervised practice) and chiropractors moving to the UK from overseas (issues around patient communication, language and familiarity with the healthcare system) that perhaps do warrant distinct CPD requirements. However,
the onus should remain on these chiropractors to plan and seek appropriate learning with the advice of their association and/or senior colleague/mentor. Clearly, new graduates are well catered for by the existing RCC PRT programme”.

The BCA noted that: “the GCC has already accepted the need for compulsory PRT in the first year of graduation and called it CPD1 (the principle was agreed by the GCC several years ago but has not been pursued). We agree with these specific requirements and completion of the PRT within 18 months of graduation is a requirement for progression to full BCA membership status”. In effect the BCA (and perhaps other associations) are placing their own requirements on new graduates.

However the SCA stated that: “there is no requirement for CPD to be different for a new graduate or those new to the register. The colleges prepare students adequately and they also have access to the RCC's PRT programme. Those registrants who have come from abroad have already proved their standard to practice in the UK by completing and passing the Test of Competence. The SCA has in place a programme of enhanced CPD for their new graduate members that must be completed within 18 months”.

There were mixed views among the eight chiropractors who responded.

One thought that there was no need for additional requirements for new graduates although colleges could do more on clinic management in the undergraduate programme. Where as another thought there should additional requirements both in undergraduate programmes and in the first year of practice including respect for other practices and their owners. Others recognised the support that new graduates need as they transfer into practice with two commenting that they had not realised that the PRT scheme was voluntary and one stating it should be made mandatory. Other comments about undergraduate programmes were made including the need for new graduates to continually develop their technique skills as these were not always well taught, and new graduates needing further understanding of fitness to practise cases.

Q22. Do you see a difference between new graduate registrants as compared with individuals who have practised chiropractic in other countries but are new to practice in the UK? If yes, what are the differences and how can they best be managed?

Three professional organisations and 4 chiropractors responded to this question. The BCA stated that: “those practising overseas are likely to be unfamiliar with UK legislation, have different ideas of what constitutes acceptable professional practice e.g. practice building activities and have skills and competencies that have deteriorated since their graduation”

The SCA and UCA commented on similar lines in terms of legislation but then made further points. The SCA expressed concerns about the question stating that: “The only difference between new graduates and chiropractors registering from overseas is their philosophy, knowledge and understanding of UK legislation. The association finds this comment quite offensive - comparing an experienced DC from overseas with a new graduate”. The UCA stating: “There is no need for CPD to be different for new graduate registrants or those new to the register. The colleges prepare the students adequately and they also have access to the RCC's PRT programme. Those registrants who have come from abroad have already proved their standard to practise in the UK by completing and passing the Test of Competence. The only

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6 Entries to the Test of Competence are not uncommon from new graduates from outwith the UK.
difference between new UK graduates and chiropractors registering from overseas is perhaps their philosophy and understanding of chiropractic practise within a particular jurisdiction’s healthcare system. New UK graduates have a direct understanding of the UK healthcare system. Overseas graduates from internationally-accredited institutions who have been practising in other countries will also have a practical and relevant understanding of a western healthcare system model. Perhaps of note, the overseas registrant may uniquely possess a broader and more acute awareness of the jurisprudence differences, as they have already been working in a regulated environment”.

There was a range of views from the chiropractic respondents. One stated that there was little difference as the standard of colleges are very similar throughout the world whereas another felt that UK graduates had undertaken a regulated, quality assured course whereas graduates from abroad are a totally unknown quantity. One noted that standards must be attained and adhered to and a cavalier approach should not be tolerated expressing concerns about any practitioner on a short term stay. One noted that the CPD needs of new graduates and experienced practitioners from overseas will be different.

The amount of CPD

Q23. Do you see any need to change the current hours requirement of a minimum of 30 hours of CPD activity? If you wish to change, please explain the benefits of doing so.

Four professional organisations and 10 chiropractors responded to this question. All four of the professional organisations that responded to the discussion document (the BCA, SCA, UCA and the RCC) stated there was no need to change the 30 hours per year requirement. The reasons given included: this being in line with other healthcare regulators and jurisdictions, and practical, manageable and proportionate.

All of the 10 chiropractor respondents also agreed that the current hours requirements should be retained. Where any reasons were given these related to them being reasonable but many chiropractors undertake more than these hours.

Q24. Is there a need for an hours requirement? If not, how should chiropractors’ engagement with the CPD requirements be assessed?

Two professional organisations and 8 chiropractors responded to this question. The SCA and the BCA responded to this question and were content with the hours requirement and its use as a minimum guide. Similar views were expressed by all of the individual chiropractors who responded seeing it as a useful guide and a potentially flawed but useful and simple method for individuals to use.

The nature of the learning undertaken

Q25. Do you think the current category of ‘learning with others’ needs to be tightened in order to meet its original intention?

Three professional organisations and 10 chiropractors, one of whom was non-practising, responded to this question. The BCA, SCA and UCA all stated they saw no need to tighten the category of ‘learning with others’, with the BCA adding that “only 16% of registrants currently use...
in-house meetings and these can be of value. The problem comes when this is misused. The issue therefore is one of verification that meetings have taken place and relevant discussions ensued”.

Nine of the 10 chiropractors who responded stated they did not see the need to change the current category of learning with others with some explaining the value it brought to their learning and development. One practitioner, who lives in a rural community some distance from other chiropractors, questioned whether due to cost sometimes driving the CPD chosen it would be possible to give further thought to the internet facilities that could be used.

Q26. How do you think the category of 'learning with others' should be improved?

Two professional organisations and 5 chiropractors responded to this question.

The SCA stated they saw no need to change the category whereas the BCA stated that: “asking for notes or minutes of meetings and the topics discussed should be made available as evidence. Local meetings beyond clinic staff should be encouraged for cross-fertilisation of ideas and peer-to-peer learning can occur”.

There was a range of comments from the individual chiropractors who responded to this question mainly commenting on the value they gain from learning with others or the issues that are associated with it. These included:

- the best learning comes from well-organised seminars and workshops and a proportion of the hours requirements should be linked to these
- learning with others often incurs high costs.

One respondent noted that they thought learning on one’s own would increase in importance over the coming years with increased CPD opportunities online whereas another stated that the current approach did not need changing.

Q27. Would you like to see an element of quality assured peer review replace the current category of 'learning with others'? If so, how would you like to see it work?

Three professional organisations and 9 chiropractors responded to this question.

The BCA considered the practicalities of introducing peer review and stated: “peer review is difficult if it is to be meaningful and fruitless if it is easy. Peer reviewers would need to be trained, there would need to be a consistency of approach which would require some sort of assessment and a process of remediation if deficiencies were found. If it is a simple scheme e.g. asking a colleague to observe some patient visits and have a discussion, it may be of limited value and as open to misuse as the current learning with others requirement”.

The SCA and the UCA stated that they: “would not like to see 'Learning with others' replaced by Peer Review as this could be costly and would become an additional cost that chiropractors have to absorb on top of the costs to pay the GCC. There is also a concern that chiropractors working in a particular practice style and / or philosophy may be penalised unduly by this. However if this was to be introduced, the Associations would be best placed to organise regional groups/ meetings”.

Most of the individual chiropractors who responded were not in favour of introducing quality-assured peer review stating a number of reasons for their views:

- there is no need to change the current approach
- it would be impractical when many practitioners are in sole employment and the time taken in peer review of a colleague equates to loss of income
• the proposals set out in paragraph 57 of the discussion document appearing too complicated and disproportionate
• practitioners should be able to self-assess without someone looking over their shoulders and there is already implicit peer review when learning with others
• concerns about terms like quality assured and how this could be implemented fairly
• practitioners guide each other informally and such an informal system would work better than a formalised system.

However, the chiropractor who thought peer review might be beneficial stated that it: “could be a useful CPD activity but it should be done in a more formal matter, perhaps a discussion between colleagues on how and when to use CPIRLS would be beneficial, if done in a confidential manner i.e. patient data protections etc”.

The CPD cycle – its length and nature

Q28. Do you agree that it is useful to retain the annual cycle of CPD?

Three professional organisations and 5 chiropractors responded to this question.

The BCA, SCA and UCA were broadly in agreement that it was useful to retain the annual CPD cycle although the SCA and UCA noted that: “it is difficult for some registrants, particularly those longer in practice, to establish a learning cycle without knowing what courses are available”. The BCA felt that annual requirements reminds registrants to stay up-to-date.

Three of the chiropractic respondents wished to retain the annual requirement whilst two did not with one arguing that 90 hours over three years would give more flexibility. However one of the respondents, who had previously been a nurse and subject to a three year cycle, stated that an annual cycle was easier to manage and if it’s longer the temptation is not to complete your CPD as you go along.

Q29. Would you like to see some elements of CPD extend over a longer period than one year? If yes, what elements might this include?

Four professional organisations and 4 chiropractors responded to this question.

All four of the professional organisations stated that if mandatory elements were to be introduced to the CPD system, such as topics related to fitness to practise cases, then there might be some value in these being over a longer timescale such as three years. This would have the benefit of allowing CPD providers to plan in advance.

Of the four chiropractors who responded, three stated that this should perhaps be allowed for programmes that lasted more than a year (such as Masters degrees) whereas one requested that the annual requirement was retained with the option of a learning cycle being longer than one year.

Q30. Do you think it would be better to move to a longer CPD cycle which included some form of annual monitoring to show that CPD was being undertaken regularly?

Three professional organisations and 3 chiropractors responded to this question.

The BCA simply stated ‘no’, the SCA stated that the current timeframe should be kept while the UCA noted that the current cycle works and there would be difficulty administering a longer timescale.

Of the three chiropractors who responded, one did not want to change on the basis that there will always be some individuals who fill it in late and would do this even
later on a longer cycle, one who thought a longer cycle should be used without any annual monitoring and one who stated “the CPD cycle of learning is confusing”.

Assessing an individual’s CPD

Q31. Do you think that chiropractors should be required to gain feedback from patients (or the people who use their services) and use this to reflect on their practice and inform the CPD they undertake? If yes, how could this be best be done?

Four professional organisations and 9 chiropractors responded to this question. The professional organisations had mixed views on whether chiropractors should be required to gain feedback from patients (or the people who use their services) and use this to reflect on their practice and inform the CPD they undertake. The RCC and the BCA both stating that this would be beneficial. The RCC stated: “patient and colleague feedback are essential components of good clinical governance and should be incorporated in a continued fitness to practice / enhanced CPD scheme”. The BCA said: “yes, if done it should use an industry standard tool eg Care Response”.

However the UCA and the SCA were not in favour of this happening stating “it should not be a requirement for a chiropractor to gain patient feedback to reflect on their practice for CPD”.

There was a range of views from individual chiropractors with most not immediately being in favour.

One stated that “it would be useful to gain feedback from patients and this could certainly be used to reflect on practice and guide CPD undertaken. We could consider the audit developed by the Royal College of Chiropractors as a useful tool to do this”. Another thought it an interesting idea but that it should not be mandatory, although if it did then practitioners should have a say in how they questioned their patients.

A number were not keen giving different reasons including:

- working in Spain and patients used a number of different languages so it would cost too much for the translation
- if patients are not happy they stop attending that chiropractor, if they approve they return and recommend us to others
- patient questionnaires are not answered by all patients and those who do answer give a skewed impression and/or the response rate would be low
- patients should not feel obligated to provide a service to chiropractors by giving feedback.

One respondent asked how this would work and whether all chiropractors would have to use the same tools or change one’s techniques at the behest of certain patients. Two other respondents which did not appear to relate to the question raising issues about undertaking annual reports and audits or the benefits of community work.

Q32. How do you think peer review could be built into the CPD system so that a chiropractor’s practice is reviewed by other practitioners?

Three professional organisations, 9 chiropractors and one person who wished to remain anonymous, responded to this question.
The SCA and the UCA stated that: “A chiropractors practice should not be reviewed by other practitioners as part of CPD. There is a concern that chiropractors working in a particular practice style and/or philosophy may be penalised unduly by this. Who would the other practitioners be? Would they have to apply to be a Peer Review Assessor? Who would pay them? - This could be costly and serve no relevance”.

The BCA noted that: “if peer review was introduced, a team of chiropractors would need to be employed, trained and their performance quality assured. An assessment process would be needed including quality assurance. An appeals process would be needed to ensure fairness where a decision is disputed”.

Of the nine chiropractors who responded, five stated that they did not wish to see peer review introduced. The remainder were less against the proposal but expressed some concerns such as whether this would encourage chiropractors to complain about each other, be difficult to implement due to the different ways of practising and different practice settings, and needing more information on the proposal before being able to comment. One proposed that perhaps peer review could be a three yearly requirement than an annual requirement preferably with a specialised group (eg educators) employed specifically for the task.

**Quality assuring CPD learning activities**

Q33. Do you see any value in approving providers of CPD for chiropractors? If so please describe what that value is?

Two professional organisations and 7 chiropractors responded to this question.

The SCA and the UCA stated that: “there could be a value in approving CPD providers, as the GCC could then be confident that the evidence provided by registrants is from a certified provider. However, some registrants travel overseas to fulfil their learning cycles, particularly if there is a specific technique that they use or are interested in and there is no UK educator”.

None of the seven chiropractors supported this idea stating that there were already plenty of providers, that this would add to the cost and reduce opportunities.

Q34. If you would like to see providers of CPD for chiropractors approved, please state how you think this could be done in a proportionate way?

Four professional organisations and 4 chiropractors responded to this question.

Both the SCSA and the UCA stated that: “all the UK Chiropractic Associations and the RCC should be approved, with any other provider or registrant having to submit an application for approval before hosting a seminar/ workshop”.

The RCC stated the opposite commenting that: “approving providers is a minefield involving commercial interests and requiring robust assessment processes and quality assurance (appeals processes etc.). Introducing an approval system could serve to reduce the scope of available CPD and this is a significant disadvantage if the onus indeed on the individual to choose CPD that is suitable for their own development”. They also stated that this is often done on an events not a provider basis which increases the size of the task.

The BCA commented on how chiropractors can be encouraged to value of CPD: “most chiropractors see the value of CPD as they spend double the minimum time doing it. Some don’t. Articles and video testimonials in chiropractic media and on the
GCC website on a series of case studies about how a named chiropractor has used CPD and the benefit for themselves as well as their patient”.

The four chiropractors who commented on this question were not in favour of recognising providers with one commenting that this might further reduce the techniques practised in the UK.

35. Are there other things the GCC could usefully do to assure the quality of the CPD that is on offer? If so, please explain what else we might seek to do.

Two professional organisations and 6 chiropractors responded to this question.

The SCA and the UCA suggested that: “the GCC could randomly investigate CPD providers outside of the associations to assure the quality of CPD provided”.

There were varied responses from the six chiropractors who responded to this question including:

- it being a difficult area
- the GCC using information provided by registrants when they undertake the annual audit of CPD, such as the providers most used by registrants and asking for further information
- it being the responsibility of registrants to select CPD providers
- ensuring that technique courses are informed by appropriate standards.

Registrants actively engaging with CPD

Q36. How can the CPD system be enhanced to encourage chiropractors to see the value of CPD in improving patient care?

Four professional organisations and 8 chiropractors responded to this question.

Of the four professional organisations, the RCC focused on achieving a good balance between prescription and self-direction for registrants to enhance engagement. The BCA recommended further work be done by the GCC to explain how registrants might undertake CPD whilst the UCA and the SCA do not feel that that current system needs enhancing.

“Ensuring active engagement is all about ensuring the chiropractor sees the relevance and benefits of CPD to their own situation. If CPD is too prescriptive, some may not engage. If the prescriptive element of CPD is not clearly justified in terms of reducing risk, again some may not engage. If the GCC is too narrow in its interpretation of what professional activity results in improved patient care, there is a danger some chiropractors will disengage, at least to the extent that their CPD activity is undertaken as a box-ticking exercise and not a process of active, self-directed learning”. (RCC)

“Most chiropractors see the value of CPD as they spend double the minimum time doing it. Some don’t. Articles and video testimonials in chiropractic media and on the GCC website on a series of case studies about how a named chiropractor has used CPD and the benefit for themselves as well as their patient”. (BCA)

“The current system works and does not need enhancing. The majority of registrants strive to improve their patients' care on a regular basis and their CPD is often more than the mandatory 30 hours, so there is no requirement for any additional encouragement”. (UCA and the SCA)
Of the 8 chiropractors who responded to this question, three emphasised the importance of simplicity of the CPD process and its recording, one emphasised the importance of self-regulation and trusting practitioners whilst another stated they thought all chiropractors want to improve results for patients and did not recognise this as a need. The remaining three expressed their surprise that other registrants did not appear to find CPD as a rewarding process and vital to improve patient care, with one unsure what to do if there are practitioners who do not think in the same way.

37. What actions do you think we should take with chiropractors who is unnecessarily obstructive or does not engage?

Four professional organisations and 8 chiropractors responded to this question.

Three of the professional organisations – the RCC, the SCA and the UCA – view obstructive behaviour or failure to engage as fitness to practise issue with the latter two suggesting that any such “chiropractor … should be placed on a warning and be expected to fulfil additional criteria within a time frame to remain on the register”. The BCA took a slightly more facilitative approach stating: “if poor compliance with the process is identified a suitable non-GCC individual, probably a chiropractor, could be available to guide and assist the registrant in a mentoring process set up, for example by the RCC as they have expertise in these areas and can ensure consistency of approach”.

Of the eight chiropractors who responded to this question, five referenced the current system and the fact that this is already designed to address those who do not engage. The mechanisms cited were the re-registration process (3 respondents) and the regular audits of CPD records (2 respondents). One chiropractor suggested that clearer definition of the key aspects followed by such compliance methods would address the issue. Similar to the pattern identified in the professional organisations, two chiropractors took what might be seen as a more facilitative approach suggesting that it might help if the GCC asked the individuals what they needed to help them engage or using a strategy which emphasised how most chiropractors are very good and do engage so promote what these registrants do to encourage the others or shame them into action.

Evidence of CPD

Q38. What evidence do you think chiropractors should provide to the GCC to demonstrate they have undertaken their CPD?

Four professional organisations and 8 chiropractors responded to this question.

The three professional associations that responded to the discussion document – the BCA, SCA and the UCA – all stated that the current requirement (of a written portfolio) is acceptable or appropriate. However the RCC urged the GCC to take the current opportunity to improve the administration of CPD. It stated:

“There is now an opportunity and we encourage the GCC to update and enhance the administration of CPD by introducing an online portfolio system. This is a well-established process. All chiropractors would record a draft personal development plan (it is important that this can be modified as learning needs/opportunities arise) at the start of the CPD period and upload their CPD activities and supporting evidence on an ongoing basis. The GCC could sample portfolios as and when appropriate. Paper-based submissions would be accepted and uploaded on behalf of registrants as an exceptional
service (but all registrants should now be using computers, smartphones or tablets on a routine basis to exchange information with the outside world, engage with electronic content etc). The portfolio system could easily keep track of any mandatory CPD that is required within a certain timeframe without additional office time being required.”

Of the eight chiropractors who responded to this question, three wished to retain the current system stating it worked well for them or in general, one proposed using the current system plus further information on why different events attended and what they learnt, while another was content with the current system as long as the requirements for learning cycles and the two learning categories were removed. Two respondents suggested the forms of evidence that might be used such as: certificates / records of attendance, receipts for CPD items such as books, travel expenses. One chiropractor recognised evidence can be difficult for some areas such as self-directed study.

Q39. Do you think that some chiropractors should have higher evidence requirements placed upon them (e.g. if they have had a fitness to practise case upheld)? If yes, what might these higher requirements be?

Four professional organisations and 6 chiropractors responded to this question.

The professional organisations had mixed views on whether some chiropractors, such as those who have had a fitness to practise case upheld) should have higher evidence requirements placed upon them. The SCA and UCA did not agree with this stating: “an individual should not have to provide higher evidence requirements if they have had a fitness to practise case upheld. Dependent on the case, and the conditions resulting from the outcome, the majority of registrants will have already learnt from the complaint and many will have changed their ways of working to improve patient care within their practice”. The BCA stated that there should only be higher requirements “if a conditions of practise order has been given otherwise it might appear that the registrant is being punished twice for the same breach. If someone has been warned about poor note-keeping, for example they could have to demonstrate that they have taken the necessary steps to reinforce the CoP order in their PDP”.

The RCC, however, saw that this might be justified under the principles of right-touch regulation stating: “It is not unreasonable (and both “proportionate” and targeted” in terms of the PSA’s principles of right-touch regulation) that those with upheld fitness to practice cases against them should have their portfolio examined on a more frequent basis”.

Of the six chiropractors who responded, two believed that there should be no changes to the current system as this was sufficient, whilst four noted that any additional CPD should be included as part of the required outcome of the fitness to practise case.

Q40. What would be the best ways of obtaining the evidence of an individual’s CPD?

Three professional organisations (the BCA, the SCA and the UCA) and 3 chiropractors responded to this question.

The three professional organisations all stated that they thought the current system of audit worked well and asking registrants to provide certificates / letters was acceptable with the UCA adding this was in consistent with other healthcare regulators and jurisdictions.
Of the three chiropractors who responded, two stated that the current system worked well and no changes should be made whereas the third stated that it was the responsibility of the registrant to ensure the necessary documentation is validated (eg by a course provider) and the GCC should not have to chase this.

Q41. Are there aspects of evidence that could be taken on trust as now with sampling for audit used for a proportion of registrants as a means of checking compliance?

Three professional organisations and four chiropractors responded to this question.

Of the three professional organisations that responded to this question, the SCA stated there should be a level of trust built into the procedures and the BCA that the current system is robust enough with a balance of encouragement and enforcement. The RCC reiterated its previous advice about moving to an online system stating: “There would be no need to consider aspects of evidence to be taken on trust if all CPD activity and evidence was retained by all registrants online”.

Of the four chiropractors who responded to this question, one stated they were happy with the existing approach whilst another stated that trust was good given chiropractors are professionals. One chiropractor pondered how to provide evidence for self-study and noted that this had to be linked to trust whilst the fourth stated that “best way to improve CPD provision to chiropractors in the UK is to only approve CPD that is evidence based”.

Other aspects that need to be considered

Q42. How can we ensure that a system of enhanced CPD is applicable to all registrants in whatever role they work?

Two professional organisations and three chiropractors responded to this question.

The SCA and the UCA stated that: “As long as a chiropractor is registered the current learning cycle system works and is applicable to all registrants in whatever role they work”. The UCA added that: “it is a relevant, broad, robust and ‘right-touch’ tool”.

Of the three chiropractors who responded, one stated that the GCC needs to “maintain the flexible approach to what constitutes appropriate CPD as long as the courses/meetings/work undertaken for the purposes of CPD upholds the CoP and SoP”. Another pleaded for simplicity and requesting learning and provider details whereas the third stated that CPD should be self-directed with the registrant deciding the CPD that is important to their role.

Q43. Is there anything in our current thinking set out in this discussion paper that will adversely affect anyone because of their gender, race, disability, age, religion or belief, sexual orientation or other aspect of equality?

Two professional organisations and three chiropractors responded to this question.

The SCA and the UCA suggested that perhaps the CPD requirements could be changed for those who take career breaks due to ill health or parental leave.

Of the three chiropractors who responded, one stated that there was nothing in the GCC’s current thinking that would adversely affect anyone in relation to equality, one stated that finance and time are the biggest issues facing chiropractors when they undertake CPD whilst the third simply stated “age (youth & mature)”.  

70
Q44. Are there any other ways of enhancing CPD that are not set out in this discussion paper that we should consider?

Six chiropractors responded to this question and made a wide range of comments on the current or a new, changed system. Due to this range, the comments have been produced in full below.

"Overall CPD great, expensive for new starters, would like more online CPD options."

"Trust. There has been a fear of recrimination and doubt amongst Chiropractors, that the GCC have been keen on marginalising Chiropractors rather than assuming they are professionals with the highest of integrity. Misguided and disgruntled people exist both as patients & professionals - and not all the people can be pleased all the time. Interpreting historical code of practice enquiries will serve a useful function if the complaints are consistently replicated, not isolated complaints interpreted as the norm."

"I cannot emphasise enough that in my opinion CPD requirements should be based on the average number of hours undertaken over the previous three years. For example, if at the time of applying for re-registration, the chiropractor has completed 80 hours of CPD, then in order to maintain an average of 30 hours per year, the next year will only require 10 hours of CPD. In the past the GCC has rejected my proposal on the grounds that the registration process must be carried out annually. I agree that applications for re-registration must be submitted annually. On each application the annual average number of hours of CPD carried out can be checked. I am pleased to note that there is a precedent for this principle. Page 10 of your discussion document refers to The Chiropractic Association of Australia referring to CPD over a two year period. At present your system makes no allowance for chiropractors approaching retirement. I agree that the CPD rules must apply equally to all chiropractors and my proposal to take the average number of hours over a three year period would apply to everyone but also allow some flexibility."

"The current online system is inadequate. The data for 2013 – 2014 has been submitted within the deadline set by the GCC. However, the new CPD year 2014 – 2015 is unable to be entered into the online platform. I have been advised that entering new CPD into the current year will be available once all the registrants CPD has been checked for 2013/14."

"If some of your proposals become reality, I worry that the atmosphere of support trust and self appraisal will disappear and be replaced by a culture based on over-rigidity of compliance, anxiety and reprisals."

"The public perception of all professions is under increasing exposure with the likes of youtube and social media - this is a crucial time for the profession to stand as a mark of quality in the UK. As a regulatory body the GCC is uniquely placed to support this role. Both the carrot and the stick are of equal importance."
Appendix D: Update on the developments related to continuing fitness to practise undertaken by the UK statutory healthcare professional regulators

Update on the developments to assure continuing fitness to practise by other UK statutory healthcare regulators

1 In 2013, the Pharmaceutical Society of Northern Ireland (PSNI) commissioned an overview of the continuing fitness to practise processes of other professions in the UK and the pharmacy profession worldwide as, like other healthcare regulators in the UK, it was in the process of actively considering how it could assure the continuing fitness to practise of its registrants. The outcomes of the work were reported to the PSNI Council in January 2014 and are available on the PSNI website (Mitchell and Moore, 2014).  

2 As the PSNI report:
   a identified and analysed the available literature on models of continuing fitness to practise, and
   b summarised and compared the different models used by other regulators in the UK and beyond to build an increased understanding of the nature, scale and effectiveness of different approaches to managing continuing fitness to practise.

   it was not necessary to repeat this process. Instead the PSNI report has been used as a baseline and set out below is an update on the thinking of the UK healthcare regulators since the end of 2013 (ie during 2014).

3 Table 1 provides an overview of the current state of play across the other UK statutory healthcare regulators in relation to developing systems to assure the continuing fitness to practise of their registrants. Table 1 was originally included in the PSNI report but has been updated in the light of the information presented.

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Table 1: UK statutory healthcare regulators use of continuing fitness to practise and current approaches to doing so (taken from the PSNI report, January 2014, where it appears as table 2.9) - updated January 2015

<table>
<thead>
<tr>
<th>Regulator</th>
<th>Explicit reference to assuring cont: FtP</th>
<th>Reported plans to amend / improve approaches to continuing fitness to practise</th>
<th>Current approach to assuring continuing fitness to practise</th>
<th>Validation of continuing competence</th>
<th>Auditing</th>
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<tbody>
<tr>
<td>GDC</td>
<td>Yes</td>
<td>Seeking enhanced CPD once necessary legislation in place</td>
<td>Mandatory CPD over 5 year cycle with extra emphasis placed on some areas whilst awaiting legislation changes eg emphasises the link to the Standards for the dental team, recommends use of PDP, reflection, CPD across the 5 year cycle. Further guidance on verifiable CPD. Use of IT system to log progress Annual registration</td>
<td>CPD returns checked to ensure meet requirements</td>
<td>Audits are carried out on a sample</td>
</tr>
<tr>
<td>GMC</td>
<td>Yes</td>
<td>Already actioned</td>
<td>Revalidation system implemented from December 2012 after extensive development work (CPD one component part) Registration and licensing</td>
<td>Based on the standards in Good Medical Practice, principally implemented through regular appraisals between a doctor and their employer. Responsible officers report to GMC every five years</td>
<td>On receipt of a revalidation recommendation from a responsible officer, a series of checks made to ensure there are no other concerns, and revalidation follows if all okay</td>
</tr>
<tr>
<td>GOC</td>
<td>Yes</td>
<td>Already actioned</td>
<td>Enhanced CET (CPD) system implemented from</td>
<td>Review of registrants’ CET activity every year</td>
<td>Audit of 10% of registrants’ reflection</td>
</tr>
<tr>
<td>Regulator</td>
<td>Explicit reference to assuring cont: FtP</td>
<td>Reported plans to amend / improve approaches to continuing fitness to practise</td>
<td>Current approach to assuring continuing fitness to practise</td>
<td>Validation of continuing competence</td>
<td>Auditing</td>
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| GOsC      | Yes – now describes as CPD which provides assurance of continuing fitness to practise | Yes undertook revalidation pilot & identified various issues. About to launch consultation on new CPD scheme consisting of current 30 hours per year plus introduction of 3 year CPD cycle:  
- CPD in each of 4 themes of Osteopathic Practice Standards  
- CPD activity in communication & consent  
- an objective activity  
- peer discussion review to complete 3 year cycle. Anticipated implementation date 2016/7 | January 2013 on a three year cycle | to confirm meeting annual requirements. Check made on every registrant at end of three year CET cycle | statements made each year by comparing the content to the learning objectives |
| GPhC      | Yes | Developing a fitness to practise framework (states revalidation only one form of | Mandatory CPD (for all except new graduates in first year of practice) Annual re-registration | Currently checks CPD annual summary forms to confirm requirements met - information used towards annual renewal of registration In future IT system will automatically confirm if individual's CPD requirements are met. Failure to engage in the process or not undertaking any of the activities will leave to removal from the register. | Samples a number of CPD record folders every year to verify their contents against the statements made on the summary form In future will audit a sample of CPD portfolios and peer discussion reviews. |

Mandatory CPD (for all except new graduates in first year of practice) Annual re-registration

Registrants’ CPD records monitored usually every five years (Registrants’ full records are assessed at least every five years)
<table>
<thead>
<tr>
<th>Regulator</th>
<th>Explicit reference to assuring cont: FitP</th>
<th>Reported plans to amend / improve approaches to continuing fitness to practise</th>
<th>Current approach to assuring continuing fitness to practise</th>
<th>Validation of continuing competence</th>
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<tr>
<td></td>
<td>assuring CFtP). Comprising:</td>
<td></td>
<td>but can be called for review at any time linked to risk – reviews by trained reviewer</td>
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<td></td>
<td>➢ CPD activities</td>
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<td></td>
<td>➢ Peer review to provide an objective view of registrant's CFtP</td>
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<td></td>
<td>➢ Performance indicator data.</td>
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<td></td>
<td>Anticipated implementation date 2018</td>
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<tr>
<td>HCPC</td>
<td>Yes</td>
<td>Stated in 2009 that current systems are sufficient. Commissioned research on current CPD system in 2014 as did the DH. Awaiting outcomes.</td>
<td>Mandatory CPD Two year cycle of registration</td>
<td>At renewal of registration individuals need to declare they have met the CPD standards</td>
<td>Audits 2.5% of registrants by profession every two years</td>
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<tr>
<td>NMC</td>
<td>Yes</td>
<td>Plan to launch &amp; implement revalidation in December 2015 using current Rules. This will replace current PREP requirements. Nurses &amp; midwives will be required to declare they have: ➢ met practice and CPD requirements ➢ reflected on their practice using the Code</td>
<td>PREP – practice &amp; CPD requirements 3 year cycle. Midwifery supervision</td>
<td>PREP – returns linked to registration Midwifery supervision – minimum annual requirement. Proposals for revalidation state based on self-declaration with evidence only needing to be submitted by those selected for audit.</td>
<td>Aims to audit but not achieved to date. Audit will occur in new revalidation system but no current information on how this will work or percentages involved.</td>
</tr>
<tr>
<td>Regulator</td>
<td>Explicit reference to assuring cont: FtP</td>
<td>Reported plans to amend / improve approaches to continuing fitness to practise</td>
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<tr>
<td>PSNI</td>
<td>Yes</td>
<td>Consideration of how to enhance current CPD model. Appears that likely to follow either the GPhC model of CPD plus objective view of registrant’s practice or model being developed by the Pharmaceutical Society of Ireland.</td>
<td>CPD became a statutory legal requirement for pharmacists in Northern Ireland on 1 June 2013</td>
<td>All registrants are required to submit their CPD portfolio annually and these are checked to ensure basic requirements being met.</td>
<td>A sample of CPD returns are sampled for more detailed assessment each year</td>
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</table>

- and feedback from others
  - received confirmation for a 3rd party.

CPD became a statutory legal requirement for pharmacists in Northern Ireland on 1 June 2013. All registrants are required to submit their CPD portfolio annually and these are checked to ensure basic requirements being met. A sample of CPD returns are sampled for more detailed assessment each year.
4 Table 1 and the other detailed information in the PSNI report and the update shows that in relation to current forms of CPD:
   a each of the UK healthcare profession regulators has a mandatory system of CPD which together with periodic registration forms the basis of assuring the continuing fitness to practise of professionals
   b only the GOC uses a model of accredited continuing education
   c regulators tend to use a model that emphasises that practitioners are best placed to decide their own learning needs and decide on the learning activities that are best suited to meet those needs
   d the use of an adult learning cycle tends to be the favoured approach although the extent to which it is used in monitoring CPD varies
   e the activities that can be recognised as counting as CPD also varies (eg the HCPC accept any activity as long as the practitioner can reflect on it and identify the learning that has taken place; the GOsC and the GCC have requirements about the need to learn with others; the GDC requires a certain percentage of activities that are verifiable in the sense of having clear aims and objectives)
   f the measures that regulators use to assess that the required CPD has taken place vary with some using a mix of outcome and input measures (eg the GCC using hours and learning cycles and the GPhC using the number of CPD entries that relate to learning cycles) whereas the HCPC focuses solely on registrants undertaking sufficient CPD to remain up to date and fit to practise
   g most regulators have some form of checking at the point of registration renewal or the end of the CPD period that requirements have been met with the GPhC probably having the most detailed approach and requirements for such returns. However the HCPC and NMC both require only a declaration from the registrant that CPD has been completed auditing only a sample of registrants for compliance
   h all of the UK regulators state they audit a sample of returns although the proportion varies (HCPC state 2.5% whereas others such as the GOC state 10%). However it appears that audit has not always been implemented (eg NMC).

5 It is evident from table 1 that the term ‘assuring continuing fitness to practise’ is now widely used by UK healthcare profession regulators. For a number this appears to have replaced the earlier focus on the term ‘revalidation’ (eg GOC, GOsC, GPhC).

6 Both the GOsC and the GPhC have decided not to use the term ‘revalidation’ as they see this as related to a specific way of assuring continuing fitness to practise. However GOsC have decided to adopt the phrase ‘continuing professional development as a means of assuring continuing fitness to practise’. The GOsC include peer review within CPD. In contrast, the GPhC see CPD as one component of assuring continuing fitness to practise with peer review as being separate from CPD.
7 The GMC is the only UK healthcare professional regulator in the UK (and possibly in the world) to have implemented a system of revalidation to date. The NMC has announced plans to pilot a form of revalidation in 2015 and introduce it from December 2015.

8 All of the regulators have standards of conduct and competence although the extent to which they are integrated, how they are presented and how they have been used in developing approaches to the assurance of continuing fitness to practise varies. The GMC has produced a framework for appraisal and revalidation from its core standards of Good Medical Practice. The GPhC states that it will use its standards of conduct, performance and ethics as the basis of assuring continuing fitness to practise. The NMC has recently published a draft, revised version of its Code and this is to form the basis of revalidation. The GOsC states that CPD should cover all four of its themes in the Osteopathic Practice Standards and has also developed four standards for assuring continuing fitness to practise.

9 Another key theme that emerges from the work of a number of regulators is the active engagement of practitioners as a central and fundamental basis of measures to assure continuing fitness to practise (eg non-engagement is the basis of referral to the GMC in medical revalidation, the GOsC has identified non-engagement as a critical issue) and where current systems span more than a year there is evidence of moves to seek annual confirmation of CPD engagement.

10 The developments undertaken by the GOsC, and to some extent the GPhC and the GDC, are likely to be those of most interest to the GCC given that they relate to what have been termed ‘high street healthcare professions’\(^2\). The GOsC is most like the GCC in the nature of the profession it regulates and the nature of its extant CPD scheme. The GDC has a five-year CPD cycle and is in the process of seeking to implement annual requirements and learning cycles within that cycle to emphasise the need for CPD to be ongoing throughout a professional’s life. The GPhC has annual requirements for CPD and annual registration but usually monitors CPD record every five years placing a strong emphasis on the use of learning cycles.

11 Overall there appears to be an interest across a number of regulators in:
   a placing annual requirements on registrants to undertake learning and development
   b having other requirements which extend over a longer term, usually three years but sometimes five (related to current legislation)
   c including an element of objective evidence / evidence from others as to the individual’s learning and practice
   d asking for CPD to be undertaken in specific areas or making recommendations of the areas in which it would be useful to undertake CPD
   e emphasising the need to develop a culture of professional learning and

\(^2\) As the GOC is the only regulator to accredit CPD activities and suppliers and having completely different forms of standards of conduct and practice, it has not been included in this discussion.
f seeing failure to engage in CPD or with the regulator as being a strong cause for concern.

12 Some of the means of assuring continuing fitness to practise that other regulators are seeking to introduce, such as peer review, have not been that favourably received within the responses to the CPD discussion document although this may be due to the way the GCC has so far explained or conceptualised these aspects. For example, some people view peer review as meaning a form of formal, summative assessment by a peer which will decide whether someone remains on the register or not, whereas others view it as a more formative process of review and discussion which enables a practitioner to think about their practice and how they might develop in the future.

13 Set out below is more detailed information on each of the regulators’ developments since the publication of the PSNI report in January 2014. As will be seen from the information set out below, most of the regulators have been refining their previous positions in this time rather than changing their direction in relation to assuring the continuing fitness to practise of their registrants.

New references and information related to continuing fitness to practise (ie post PSNI report)

**General Dental Council**

The legislation governing the GDC defines CPD as:

“CPD for dental professionals is defined in law as: lectures, seminars, courses, individual study and other activities, that can be included in your CPD record if it can be reasonably expected to advance your professional development as a dentist or dental care professional and is relevant to your practice or intended practice.”

The CPD guidance emphasises the link to the Standards for the Dental Team and the role of CPD in helping registrants practise in accordance with those standards.

The use of a Personal Development Plan (PDP) to help make good CPD decisions is strongly recommended by the GDC as it will help identify learning needs and meet them in a structured way. Reflection on what has been learned either individually or with others is also recommended as is undertaking CPD across all of the five year cycle.

At the end of each CPD year the GDC will ask registrants about the CPD they have done that year or registrants can inform the GDC by logging onto the eGDC after each CPD activity they have undertaken and logging the information themselves.

Towards the end of a five-year CPD cycle the GDC will send registrants a statement of the CPD hours they have stated have been undertaken in the cycle for them to check. Registrants will need to send an end-of-cycle declaration when asked to do so by the GDC.

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New guidance was introduced by the GDC (as explained in accompanying Questions and Answers) because of the new Standards for the Dental Team and to allow CPD guidance to be contained in one document for all registrants (previously there had been separate guidance for dentists and dental care professionals).

The website contains case studies of the CPD that different registrants have undertaken and how this meets the CPD requirements.

The GDC have provided a broad overview of the outcomes of the consultation on changing the CPD Rules. The GDC received just over 600 responses to the consultation including 39 organisational responses. The responses indicated overall support for: the proposed high level CPD learning outcomes, the requirement to undertake a minimum of 10 hours CPD in each consecutive period of 2 years, and the proposed CPD documentary evidence required.

Respondents emphasised the need for a clear approach to the transition between the extant and enhanced system including additional information. They expressed concerns about: whether registrants would be able to undertake CPD outwith the UK, the quality of CPD available in dentistry, and access, availability and costs of CPD activities.

The GDC website states that it has not yet made any final decisions about future continuing assurance policies and procedures.

The PSNI report states that “The GDC is currently working with the Department of Health on the development of Rules to introduce an enhanced system of CPD and … the earliest the enhanced system will be in place is 2014”. One can assume that the necessary legal work was not undertaken by the Department of Health in time for the GDC’s Rules to be changed in 2014.

The GDC places requirements on its registrants in relation to the total amount of CPD they must undertake in a five-year cycle and within that total amount the amount that must be verifiable:

- dentists must undertake a minimum of 75 hours of verifiable CPD
- DCPs must undertake a minimum of 50 hours verifiable CPD.

Verifiable CPD is defined in law as “having documentary evidence that the dentist or DCP has undertaken the CPD and documentary evidence that the CPD has:

- concise educational aims and objectives
- clear anticipated outcomes, and
- quality controls.

It is recommended that registrants are proactive in assuring themselves that the verifiable CPD they undertake has adequate quality controls in place at all stages of verifiable CPD activity and offers some examples of what such quality controls might look like. For example:

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4 General Dental Council, (undated – 2013?). Revised CPD Guidance – Q&As. London, GDC.
5 http://www.gdc-uk.org/Dentalprofessionals/CPD/Pages/CPD-case-studies-.aspx
7 http://www.gdc-uk.org/Aboutus/policy/Pages/policitem.aspx?policy=Continuing%20assurance%20of%20fitness%20to%20practise
8 General Dental Council, (September 2014). Quality controls for verifiable CPD. London, GDC.
• before the CPD activity – relevant policies (eg equality and diversity, educational governance), content linked to GDC standards, delivery of evidence-based content
• during the CPD activity – robust methods of confirming attendance and participation, documentary evidence of aims, objectives, anticipated learning outcomes and quality controls provided to every participant for them to keep, assessment of learning
• after the CPD activity – participant evaluation, a complaints procedure.

**General Medical Council**

In 2013 the GMC commissioned the University of Plymouth to develop an evaluation framework for revalidation\(^9\). The GMC has appointed a team led by the Collaboration for the Advancement of Medical Research and Assessment (CAMERA) at Plymouth University, to undertake a long-term evaluation of revalidation using the evaluation framework. This started in autumn 2014, an interim report is expected in 2015, and a final report is scheduled for 2017.

Operational data reports for each of the four UK countries are available on the GMC website and updated monthly\(^10\).

In March 2014, the GMC published its third edition of a protocol for responsible officers and suitable persons\(^11\). This provides guidance on making fair and reliable recommendations by:

• describing the three categories of recommendations that can be
• providing detailed criteria for making consistent, fair and robust recommendations
• outlining the steps that should be taken when submitting recommendations to the GMC.

**General Optical Council**

There does not appear to be any new publications as the GOC is in the process of implementing its Enhanced CET.

**General Osteopathic Council**

In July 2014, the GOsC Council received a draft continuing fitness to practise model comprising draft CPD guidelines, draft peer review guidelines and the draft outcomes of a research report on patient and public views about continuing fitness to practise. The draft guidelines had been and continued to be developed with four cross-regional pathfinder groups across three of the four UK countries, the osteopathic educational institutions, member organisations of the Osteopathic Alliance and the

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\(^10\) http://www.gmc-uk.org/doctors/revalidation/revalreports.asp

Institute of Osteopathy. The benefit of the pathfinder model to inform development was seen as encouraging and helpful. The Council also recommended and agreed a consistent terminology to be used in the GOsC developments which is: "continuing professional development which provides assurance of continuing fitness to practise". It is believed that this terminology will be familiar to registrants, they will be comfortable with it and it will help them to engage in the consultation.

On 6 November 2014, the GOsC Council received full draft proposals for consulting on a new CPD scheme and to consider the consultation strategy. The proposals comprised:

A. Background booklet for all registrants – outlining the development process, why the changes to CPD are being proposed and encouraging them to become involved with the consultation

B. The General Osteopathic Council consultation on continuing professional development: proposals for assuring the continuing fitness to practise of osteopaths: a summary (short consultation document) – a short summary of the consultation document designed for patients and others who wish to respond in general terms to the consultation

C. The General Osteopathic Council consultation on continuing professional development: proposals for assuring the continuing fitness to practise of osteopaths – the main consultation document which sets out all the consultation questions. The consultation is designed to allow individuals and organisations to respond to all aspects of the consultation or specific aspects of it.

D. Draft Continuing Professional Development Guidelines

E. Draft Peer Discussion Review Guidelines – to support people preparing for and undertaking peer discussion

F. Consultation strategy presentation

The GOsC intend that examples, resources and case studies for each of the mandatory requirements will appear separately on the consultation pages of the GOsC website to illustrate the way that the scheme might work in practice.

The proposed GOsC scheme is outlined in a diagram as shown on the following page.

The consultation proposals state that:

1. As now, it will consist of 30 hours of CPD (including 15 hours of learning with others) as are the current requirements which over 3 years totals 90 hours of CPD (including 45 hours learning with others). It will continue to be primarily self-directed

2. In the future it will also include the following:
   a. CPD in each of the four themes of the Osteopathic Practice Standards – the GOsC’s version of the Code of Practice and Standard of Proficiency
   b. a CPD activity in communication and consent

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12 http://www.osteopathy.org.uk/about/the-organisation/meetings/
13 The Osteopathic Practice Standards are grouped into four themes: communication and patient partnership; knowledge, skills and performance; safety and quality in practice; professionalism.
c. an objective activity (e.g., a case-based discussion, peer observation and feedback, patient feedback or clinical audit)

d. the three year CPD cycle being completed by a Peer Discussion Review with a colleague to discuss CPD and practice and demonstrating engagement with the CPD scheme.

The GOsC state that CPD scheme needs to change; currently CPD (which is similar to that operated by the GCC) does not show the public and patients how osteopaths keep up to date with the standards that are set.

The CPD scheme should:

- enable GOsC and registrants to respond to the question ‘how can I know that the professional looking after me is up-to-date and fit to practise?’
- support a culture of continuous learning and improvement – the GOsC emphasises the need to promote engagement, discussion and learning communities within osteopathy
- not encourage behaviour that could put public protection at risk
- support genuine enhancement of practice and engagement.

The GOsC notes that currently its registrants often undertake CPD in areas that they find of interest (e.g., new techniques or refreshing their knowledge of techniques). However the GOsC believes that CPD should cover a wide range of activities including keeping up to date in other areas (e.g., communicating effectively with patients, safety and quality and professionalism). The need for these areas is reinforced by the fitness to practise cases that GOsC receives and the nature of osteopaths’ interactions with patients. This is why the GOsC has placed an emphasis on effective communication and consent in its proposals as well as gaining the views of others on practice in order to support the demonstration of standards and enhance the quality of care.

The CPD related to communication and consent can be carried out using a variety of resources (e.g., group discussion, courses, e-learning or self-study) and a guideline of three hours has been given for this activity.
Table 1: An overview of GOsC’s proposed new CPD scheme – *taken from GOsC Background to the new CPD scheme, December 2014.*

<table>
<thead>
<tr>
<th>Proposals for a new CPD scheme: a diagram</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The new CPD model</strong></td>
</tr>
<tr>
<td>30 Hours CPD each year</td>
</tr>
<tr>
<td>(90 hours over 3yrs)</td>
</tr>
<tr>
<td>15hrs learning by self</td>
</tr>
<tr>
<td>15hrs Learning with others</td>
</tr>
</tbody>
</table>

CPD must be completed in ALL categories

**Osteopathic Practice Standards**
- CPD covers key themes from the Osteopathic Practice Standards:
  - Communication & patient partnership
  - Knowledge, skills & performance
  - Safety & quality in Practice
  - Professionalism

**Objective Activity**
- At least 1 activity from below:
  - Patient feedback
  - Peer review
  - Clinic audit
  - Case base discussion
  - (Ost can meet Standard 2)

**Communication and consent**
- Every 3 years all Osteopaths must carry out a CPD activity in consent
  - (Ost can meet standard 3)

**Maintaining a CPD portfolio**
- Maintaining an annual portfolio of CPD activities with documented evidence
  - (Ost can meet standard 4)

You must be able to demonstrate how it has influenced your CPD or

At the end of the 3 year cycle you undergo a peer discussion review with another osteopath or health professional

**CPD Standards**
1. CPD activities are relevant full range of Osteopathic practice
2. Objective activities have contributed to practice
3. Seek to ensure that CPD activities benefit patients
4. Maintain a continuing record of CPD
The objective activity – gaining the views of others - will be done at the start of every three year CPD cycle through one of the following methods:

- seeking patient feedback (e.g., through the use of questionnaires)
- observation of practice by a peer
- discussing elements of practice or specific cases with colleagues
- undertaking an audit of an individual’s practice.

The objective activity will be recorded and has the aim of ensuring that the registrant undertakes appropriate CPD based on feedback from another about their practice.

At the end of the three-year cycle registrants will review with their peers what they have done and whether this was as expected and if there is benefit in them doing more. The reviews might be: with colleagues, by an employer, by a college, by a society or regional group or by the GOsC if no-one else was available. Registrants will be able to decide for themselves who their peer in order for this to be in a professional safe space. Peer discussion review is intended to be a supportive process that enables individuals to learn from each other and demonstrate that they provide a quality experience for patients. It can be undertaken one-to-one or in a group format. Both parties in a peer discussion review can count the time spent as contributing to their total CPD hourly requirements of 90 hours across the three-year cycle. It is anticipated that the process will take about 60 – 90 minutes.

Appropriate governance and quality assurance arrangements will be put in place for the peer reviews. Online training will be provided for peer discussion reviews.

Each year the GOsC’s IT system will:

- provide feedback to registrants on whether or not they are on track with their three year CPD cycle
- automatically audit submissions at the end of the three year cycle to ensure all of the requirements have been undertaken and recorded.

Quality assurance will be through an audit of a sample of CPD portfolios and peer discussion reviews will be undertaken. The reviewer will not be penalised unless there is clear evidence of collusion.

Failure to engage in the process or not undertaking any of the activities will leave to removal from the register. If and when peer review identifies that an individual needs further development, then s/he is expected to undertake this to ensure that they meet the required standards. The GOsC will carry out checks that the reviews are working as intended and that registrants are not seeking to avoid requirements.

The GOsC proposes that its new CPD scheme is based on four CPD standards. These standards will be demonstrated in the peer review at the end of the three year CPD cycle. These are shown in the table below adapted from the GOsC consultation documents.

<table>
<thead>
<tr>
<th>CPD standards</th>
<th>Outcomes</th>
<th>Shown by</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Range of</td>
<td>Demonstrate that activities are</td>
<td>Undertaking and recording</td>
</tr>
<tr>
<td>CPD standards</td>
<td>Outcomes</td>
<td>Shown by:</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>practice</td>
<td>relevant to osteopathic practice</td>
<td>CPD in four themes of the Osteopathic Practice Standards</td>
</tr>
<tr>
<td>2. Quality of care</td>
<td>Demonstrate that objective activities have contributed to practice and the quality of care</td>
<td>Completion and recording of at least one objective activity in the three year cycle</td>
</tr>
<tr>
<td>3. Patients</td>
<td>The registrant has sought to ensure that CPD benefits patients</td>
<td>Undertaking CPD in communication and consent – approx.: 3 hours</td>
</tr>
<tr>
<td>4. Portfolio</td>
<td>Maintain a continuing record of CPD</td>
<td>Discussion and review of the CPD folder as part of the Peer Discussion Review</td>
</tr>
</tbody>
</table>

The GOsC’s proposed timescale for the development is as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2015 to May 2015</td>
<td>Consultation Engagement meetings</td>
</tr>
<tr>
<td>June to September 2014</td>
<td>Analysis of responses and production of report</td>
</tr>
<tr>
<td></td>
<td>Consideration of implementation issues e.g. IT specification and legislation</td>
</tr>
<tr>
<td>13 October 2015</td>
<td>Osteopathic Practice Committee – consideration of responses and next steps</td>
</tr>
<tr>
<td>12 November 2015</td>
<td>Council – consideration of responses and next steps</td>
</tr>
<tr>
<td>2016</td>
<td>Early adopters and infrastructure development</td>
</tr>
<tr>
<td>2016/2017</td>
<td>Full implementation</td>
</tr>
</tbody>
</table>

The consultation was launched on 10 February 2015 and has a closing date of 31 May 2015.
The General Pharmaceutical Council

The PSNI report shows the state of play in the regulators up to the end of 2013. At that point in time the GPhC had agreed to develop a draft continuing fitness to practise framework. Since 2013, the GPhC has revised its initial timetable for developing continuing fitness to practise whilst retaining the planned implementation date of 2018\(^{14}\).

The GPhC is using the term ‘continuing fitness to practise’ to refer to a range of methods that can be used to support pharmacists and pharmacy technicians to demonstrate how they meet the GPhC’s standards. It is intended that the process will provide further assurance to the public that they will receive an appropriate standard of treatment and care from pharmacy professionals.

The aim of introducing continuing fitness to practise mechanisms is:

- to support professionals to remain up-to-date and continuously improve their practice and through this outcomes for patients and service users in a culture of patient-centred professionalism
- to identify the small number of individuals who may be falling short of our standards so that appropriate action can be taken to support improvement or, if necessary, remove them from the register.

The continuing fitness to practise framework will consist of three elements:

1. CPD activities – already a mandatory requirement and will become part of the evidence for continuing fitness to practise
2. Peer review undertaken by a partner organisation to provide an objective point of view of a registrant’s continuing fitness to practise
3. Performance indicator data to provide more objective evidence.

A team within the GPhC is undertaking the development of the framework with the active involvement of a continuing fitness to practise advisory group. The group consists of a number of attending members across different stakeholder groups (including two Council representatives) as well as corresponding members. It held its first meeting on 2 December 2014\(^{15}\). The advisory group will focus on:

- how CPD, peer review and any other relevant indicators of professionalism might be included in the continuing fitness to practise framework
- how to pilot, test and evaluate the different options in practice
- the criteria and methodology for assessing the impact of the continuing fitness to practise framework
- how to involve patients’, service users’ and professionals’ views in the development.

The provisional timing for the development is:

<table>
<thead>
<tr>
<th>Date</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>Testing – what works for particular registrants,</td>
</tr>
</tbody>
</table>

\(^{14}\) GPhC, September 2014, Developing the draft continuing fitness to practise framework. Paper to the GPhC Council September 2014. London, GPhC.

\(^{15}\) Information on the developments is available at: [http://www.pharmacyregulation.org/registration/continuing-fitness-practise](http://www.pharmacyregulation.org/registration/continuing-fitness-practise)
### Date | Activities
--- | ---
Employers, commissioners and patients and the public
Research – on whether current CPD processes need to change and on identifying and using performance indicators
2016/17 | Piloting – to identify the real impact of the proposals and their costs and benefits
Evaluation – during the developments that the framework is having the intended impact
2017/18 | Consultation – to ensure stakeholders understand the plans when they are closer to being finalised and to enable them to give their views
Preparation – to ensure that stakeholders have the information they need for implementation
2018 | Implementation
Evaluation – to ensure that that the framework is having its intended impact and improves over time.

**Health and Care Professions Council**

As described in the PSNI report, the HCPC has consistently taken the view that its current processes already provide assurance of continuing fitness to practise. A paper to the HCPC’s Education and Training Committee on 5 June 2014, sets out a research brief to gather feedback from a range of stakeholders on the existing standards and CPD process\(^{16}\). The purpose of the research is to inform any future changes to the standards, audit process and communication materials and forms part of a wider programme of work exploring continuing fitness to practise.

The paper also notes and provides the research brief issued by the Department of Health investigating the costs and benefits of the HCPC’s approach to CPD standards and audits. The invitation to tender was issued in May 2014 but due to the size of the work the contract was not expected to be awarded until December 2014 with the an anticipated completion date for the research being a year after its commencement (ie early January 2016 if all goes to plan).

In December 2014, the HCPC Council received the final year progress report from the University of Durham on its research into measuring professionalism\(^{17}\). The work is due to conclude in mid 2015 with the anticipated outcomes being a validated tool that can be used by individual professionals and their employers to explore professionalism. The paper noted that a verbal update on the continuing fitness to practise programme of work was given at the Council’s away day in October 2014 and that a paper will be presented to the February 2015 Council meeting.

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\(^{16}\) HCPC, June 2014, CPD research: Executive summary and recommendations. Paper for the Education and Training Committee of the HCPC. London, HCPC. Available at: [http://www.hpc-uk.org/assets/documents/10004644Enc03-CPDresearch.pdf](http://www.hpc-uk.org/assets/documents/10004644Enc03-CPDresearch.pdf)

Nursing and Midwifery Council

As briefly described in the PSNI report, the NMC committed to developing a system of revalidation in 2013. The NMC intends that new revalidation requirements will replace the extant Prep – Post-registration education and practice – requirements in December 2015. Under revalidation, nurses and midwives will be required to declare they have:

- met the 450 hours of practice in three years and CPD requirements
- reflected on their practice based on the requirements of the Code and using feedback from patients, colleagues and others
- received confirmation from a third party.

Revalidation evidence will only need to be submitted when a registrant is selected for audit. It is stated that the model has been developed in line with the NMC’s current legislative framework.

The NMC completed a six-month consultation in August 2014 which involved two online surveys, workshops and focus groups as well as other stakeholder engagement activities relating to revalidation and a draft revised Code. The NMC published a Code Evidence Report (NMC, no date(a)) alongside the redevelopment of the Code to explain how evidence had informed the development of the Code and a Revalidation Evidence Report (NMC, no date(b)) providing a summary of the main evidence to support the planned revalidation pilots and the continuing development of revalidation.

The draft Code set out:

- patient and public expectations – what people in the care of nurses and midwives can expect
- standards of conduct, performance and ethics for good nursing and midwifery practice
- a glossary
- that guidance will be issued on a number of areas to underpin the Code including:
  - revalidation
  - social networking
  - professional indemnity insurance
  - candour
  - raising concerns
  - medicines management
  - good health and character.

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In December 2014 the NMC Council considered a draft revalidation policy for piloting as well as the final draft versions of the Code\textsuperscript{19}. The revised Code: Professional standards of practice and behaviour for nurses and midwives was published on 29 January 2015 and comes into effect from 31 March 2015.

It is structured around four themes of:

- Prioritise people
- Practise effectively
- Preserve Safety
- Promote professionalism and trust.

It contains 25 statements in total grouped under these four themes. Each of the statements has sub-statements to add greater clarity.

The patient and public expectation section has been removed as a separate section with the information now being included in introductory statements to each section of the Code. The glossary has also been removed with the intention that such information will be available online. The NMC media coverage for December 2014 reports that the Council agreed and approved the revised Code\textsuperscript{20}.

At the December 2014 meeting, the NMC Council also considered a provisional policy to support the revalidation pilots. This sets out how the different aspects of the revalidation proposals are covered by the NMC legislation and Rules.

The NMC plans to publish revalidation guidance by the end of January 2015 and use this with the revised Code in the revalidation pilots that will start in January 2015. The pilots are due to complete in June 2015. Detailed information on the nature of the pilots did not appear to be available at the time of writing.

The NMC Council will consider the outcomes of the pilots in November 2015 and agree any refinements to the model and supporting guidance prior to the launch and implementation of revalidation in December 2015. An independent supplier will be commissioned to assess the effectiveness of the revalidation model from late 2016.

\textsuperscript{19} Revision of the Code - \url{http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council%202014/Council%20papers%2020141203%20FINAL%20PDF.pdf}
\textsuperscript{20} \url{http://www.nmc-uk.org/media/Latest-news/NMC-in-the-News14/}
Pharmaceutical Society of Northern Ireland

CPD became a statutory legal requirement for pharmacists in Northern Ireland on 1 June 2013. In April 2014 the PSNI published a new CPD framework (PSNI, 2014(a)). This document brings together two previous documents and introduced some key changes including:

- All registrants needing to submit their CPD portfolio records by 31 May each year.
- Each submission to include:
  - a minimum number of four entries for learning cycles
  - a minimum 30 hours of CPD activity each year
  - a ‘predominance’ of scheduled learning activity that includes a reflective approach to practice
  - a record of whether the CPD activity is relevant to the safe and effective practice of pharmacy and to the registrant’s scope of practice
- Registrants who submit unsuccessful portfolio records will be offered two time-bound remediation opportunities.

A sample of CPD returns will be sampled for more detailed assessment each year (PSNI, 2014(b)). The PSNI has produced an online CPD manual to enable registrants better meet their CPD requirements21. This includes sections on: the CPD requirements, the CPD cycle, CPD recording, exemplars, and a self-test.

The Council of the PSNI having received the report from Prime R&D Ltd on continuing fitness to practise in January 201422. The Council expressed support for option 4 that was outlined in the report “strengthen existing PSNI regulatory policies and procedures” and for using this option to building on the robust CPD process that was scheduled to begin in June 2014. The Council also noted that the policy of the Northern Ireland Government Department (DHSSPSNI) was not to advance continuing fitness to practise for pharmacy in Northern Ireland.

Overall the PSNI Council agreed to record their commitment to the principle of continuing fitness to practise and recognised the need for a clear timetable and a named person to lead the overall project. It concluded that further work would need to be undertaken by the Council to evaluate two of the four options:

- option 4 strengthen existing PSNI regulatory policies and procedures, and
- option 3 import and adopt an established revalidation model from another regulator

in the context of the Manchester University report into assessing risk into contemporary pharmacy practice in Northern Ireland. It was not possible to find any further information of such a development on the website.

References – additional to those available in the full PSNI report (January 2014)

21 http://cpd.psni.org.uk/manual/


General Dental Council, (undated – 2013?). Revised CPD Guidance – Q&As. London, GDC.


General Dental Council, (September 2014). Quality controls for verifiable CPD. London, GDC.


General Osteopathic Council, October 2014, Peer discussion review form guidance DRAFT 7, London, GOsC.

General Pharmaceutical Council, September 2014, Developing the draft continuing fitness to practise framework. Paper to the GPhC Council September 2014. London, GPhC.


23 All of these GOsC documents are available at: http://www.osteopathy.org.uk/about/the-organisation/meetings/


Nursing and Midwifery Council, December 2014, Provisional policy for the revalidation of nurses and midwives – Council paper, London, NMC.

Pharmaceutical Society of Northern Ireland, 2014(a), CPD Standards and Framework, Belfast, PSNI.

### Appendix E: Setting the proposals for taking forward the assurance of a continuing fitness to practise of chiropractors against the extant Continuing Professional Development Rules 2004

In the table below, we have considered how the current Rules facilitate or prohibit us moving forward in the short term. Legal advice will need to be sought prior to ensure that our interpretation is correct.

<table>
<thead>
<tr>
<th>Current rules</th>
<th>Proposals</th>
<th>Possible steps towards proposals</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interpretation</strong> - other aspects are defined in the Rules but these are not included here as covered more clearly lower down in the table</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPD means training which comprises lectures, seminars, courses, practical sessions, individual study or other activities undertaken by a registered practitioner which could reasonably be expected to advance his professional development as a chiropractor or contribute to the development of the profession of chiropractic.</td>
<td>Clarify what counts as CPD now and where the GCC would have concerns</td>
<td>The current definition of CPD is rather out-of-date with its emphasis on training rather than learning and development - it would ideally be changed in new rules. The current definition of CPD refers to ‘advance his professional development as a chiropractor or contributing to the development of the profession of chiropractic’ – this is the closest reference to the two learning categories.</td>
<td></td>
</tr>
<tr>
<td>“Learning with others” means any CPD other than individual study (para 2)</td>
<td>Clarify how this is interpreted now including which aspects of online learning would count as ‘learning with others’</td>
<td>This is rather a weak definition being the negative of learning on one’s own – potentially could be improved</td>
<td></td>
</tr>
<tr>
<td><strong>CPD year</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>A CPD year shall run from 1st September to 31st August. (para 3)</td>
<td>Para 50(f) Potentially include CPD years starting in different months for different registrants so as to better spread the office workload and enable trained office staff to run the scheme throughout the</td>
<td>Plot out how this might work and the benefits and drawbacks</td>
<td>This will need a lot of thought and planning across different strands of the GCC including business planning and finance.</td>
</tr>
<tr>
<td>Current rules</td>
<td>Proposals</td>
<td>Possible steps towards proposals</td>
<td>Notes</td>
</tr>
<tr>
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</tr>
<tr>
<td>year Para 50 (d) introduce requirements to take place across a three year cycle and which would count against the hours requirements for those three years (90 hours in total) of:</td>
<td>Prior to the introduction of such requirements:</td>
<td>The current Rules are based on CPD being with years and there are no requirements across years. Assume that it is not possible to change this without a change to the Rules.</td>
<td></td>
</tr>
<tr>
<td>i. an objective activity (eg a case based discussion, peer observation and feedback, patient feedback or clinical audit) – this could build, for example, on the tools already developed by the RCC</td>
<td>i. work with the profession and other stakeholders to refine the proposals and develop appropriate guidance and exemplars</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. a CPD activity in an area identified by the GCC as of importance to the profession as a whole and which might change over time – these areas would be from persistent issues in fitness to practise cases or where, for example, new legislation has been introduced</td>
<td>ii. recommend to registrants that they start doing these activities and report them in their learning cycles explaining clearly how this will benefit them and their practice – without placing such requirements on them</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii. a peer discussion to demonstrate engagement with learning and development and reflective practice</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CPD requirement for registered chiropractors**

<p>| 4.1 Subject to rule 10, every registered chiropractor (whether practising full-time or part-time, or non-practising, or whose | |
| | | | |</p>
<table>
<thead>
<tr>
<th>Current rules</th>
<th>Proposals</th>
<th>Possible steps towards proposals</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>registration is or has been suspended under any provision of the Act) shall complete the CPD requirement during the course of a CPD year.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 4.2 Subject to rules 9 and 10, the CPD requirement shall consist of: (a) the completion of at least 30 hours of CPD of which at least 15 hours shall involve the verifiable (by or on behalf of the Council) participation of the registered chiropractor in learning with others; and (b) the completion of at least one learning cycle as described in paragraph (3) (which shall entail the completion of CPD that counts towards the 30 hours total in sub-paragraph (a)). | a retain an annual cycle which requires 30 hours of learning of which at least 15 hours is learning with others  

b retain the use of learning cycles as the basis of planning, undertaking and reflecting on learning  

c remove the requirement for the learning to be categorised as 'improving patient care' or 'developing the profession' | The first two proposals to retain what is in the Rules already require no change and hence no steps.  

The third proposal – remove the requirement for the learning to be categorised as ‘improving patient care’ or ‘developing the profession’ is not within the current Rules so could potentially be implemented for the forthcoming CPD year. | Interesting that current Rules include the term ‘verifiable’ as this is not used elsewhere in the GCC documentation – presumably means / has been interpreted as capable of being supported by evidence |
| 4.3 For the purposes of paragraph (2)(b), a learning cycle shall consist of the following four stages—  

(a) reflecting on and assessment by a registered chiropractor of his learning needs and interests within the context of his professional practice;  

(b) planning how the registered chiropractor intends to meet the learning needs or interests identified in accordance with sub-paragraph (a) and recording this in a personal development plan (which may be revised as necessary during the CPD year); |                                                                                                                                                                                                           |                                                                                                                                                                                                                                         | This further explains learning cycles and their component parts – relates to proposal (b).                                                                                                                   |
<table>
<thead>
<tr>
<th>Current rules</th>
<th>Proposals</th>
<th>Possible steps towards proposals</th>
<th>Notes</th>
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<tr>
<td>(c) undertaking CPD in accordance with the personal development plan; and</td>
<td>Para 51(b) an improved system of online recording is developed alongside the new / revised CPD system using up-to-date ICT</td>
<td>Investigative work into a suitable ICT system for the revised / new CPD scheme possibly working in partnership with the GOsC / RCC.</td>
<td>An improved system of online recording would negate some of the detail in the Rules about producing the CPD record on demand if a system which allows the GCC to monitor progress electronically is introduced</td>
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<tr>
<td>(d) evaluating CPD undertaken and its effectiveness in meeting the learning needs or interests identified in the personal development plan.</td>
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<tr>
<td><strong>Obligation to keep CPD records</strong></td>
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<tr>
<td>5 (1) A registered chiropractor shall—</td>
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<td>(a) keep an up to date record of CPD undertaken during a CPD year to be</td>
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<td>known as a CPD Record; and</td>
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<tr>
<td>(b) produce the CPD Record to the Council on demand.</td>
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<td>(2) The CPD Record shall include a record of each stage of the registered</td>
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<td>chiropractor’s learning cycle and shall be in such format as the Council</td>
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<td>may from time to time specify</td>
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<tr>
<td><strong>Compliance with CPD requirement (para 6)</strong></td>
<td></td>
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<tr>
<td>6. (1) Subject to paragraphs (6) and (7), the Registrar shall send to every</td>
<td>Para 51(b) an improved system of online recording is developed alongside the new / revised CPD system using up-to-date ICT</td>
<td></td>
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<tr>
<td>registered chiropractor annually—</td>
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<tr>
<td>(a) a summary sheet to be completed by the registered chiropractor showing</td>
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<tr>
<td>the CPD he has undertaken;</td>
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<tr>
<td>(b) a notice requiring the registered chiropractor to complete the summary</td>
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<td>sheet and return it to the Registrar by the date specified in the notice</td>
<td></td>
<td></td>
<td>As per section above, the Rules could be simplified to allow for the use of improved ICT.</td>
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<tr>
<td>(“the return date”), which shall be at least 28 days</td>
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<td></td>
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<tr>
<td>Current rules</td>
<td>Proposals</td>
<td>Possible steps towards proposals</td>
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<tr>
<td>after the date of the sending of the notice; and</td>
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<td></td>
<td>The remainder of this section of the Rules focuses on submission of summaries etc and how this is handled by the office. This would all need to be reviewed if an updated system was introduced but otherwise stands as is at present</td>
</tr>
<tr>
<td>(c) a warning that unless the completed summary sheet is received by the Registrar by the return date, the registered chiropractor’s name may be removed from the register.</td>
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<tr>
<td>(2) Where the completed summary sheet is not received by the Registrar by the return date, he shall send a notice of final warning to the registered chiropractor warning him that, if the completed summary sheet is not provided before the end of the period of 14 days beginning with the day on which the notice was issued (“the final warning date”), his name may be removed from the register.</td>
<td></td>
<td></td>
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<tr>
<td>(3) If the completed summary sheet is not received by the final warning date, the Registrar may remove the name of the registered chiropractor from the register.</td>
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<tr>
<td>(4) Where the Registrar is not satisfied from the information provided in the summary sheet or otherwise that the registered chiropractor has complied with the CPD requirement he shall send a notice to the registered chiropractor which shall include— (a) a statement of the reasons why he is not satisfied that the registered chiropractor has complied with the CPD</td>
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<td>Current rules</td>
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<td>requirement; (b) an invitation to the registered chiropractor to submit his observations on the matter by the date specified in the notice, which shall be at least 14 days after the date of the sending of the notice; and (c) a request that the registered chiropractor produce within the same period his CPD Record for the relevant year.</td>
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<tr>
<td>(5) Where— (a) the registered chiropractor fails to produce his CPD Record by the date specified in the notice sent under paragraph (4); or (b) after considering any observations submitted by the registered chiropractor pursuant to paragraph (4)(b) and the contents of the CPD Record, the Registrar remains of the view that the registered chiropractor has not complied with the CPD requirement for the year in question, the Registrar may remove the name of the registered chiropractor from the register.</td>
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<tr>
<td>(6) The Registrar shall not send the documents mentioned in paragraph (1) to a person— (a) who has received notification under section 20(9)(a) of the Act and is subject</td>
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<tr>
<td>Current rules</td>
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<td>to an investigation under sections 20, 22 or 23 of the Act in connection with all proceedings and appeals arising have not been completed (or the time for all such appeals has not expired); or (b) whose registration is suspended, until the relevant event set out in paragraph (7) occurs at which time the Registrar shall send to the chiropractor the documents mentioned in paragraph (1), and paragraphs (2) to (6) shall have effect accordingly.</td>
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<tr>
<td>(7) The event mentioned in paragraph (6) is— (a) completion of any investigation referred to in paragraph (6)(a) and of all proceedings and appeals arising from it, or as the case may be upon the expiry of the time for any such appeal without such appeal being made, where the decision is not one that the chiropractor’s name be removed from the register or his registration suspended; or (b) the ending of the suspension referred to in paragraph (6)(b).</td>
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<tr>
<td>(8) Whenever the Registrar removes the name of a chiropractor from the register under this rule, he shall notify the chiropractor in writing of the removal and of the reasons for it.</td>
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<tr>
<td>Current rules</td>
<td>Proposals</td>
<td>Possible steps towards proposals</td>
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<tr>
<td>7 Restoration to the register following removal for non-compliance</td>
<td></td>
<td></td>
<td>This section has not been given in full as does not need to be considered for this exercise</td>
</tr>
<tr>
<td>8 Appeals from decisions of the Registrar</td>
<td></td>
<td></td>
<td>Ditto</td>
</tr>
<tr>
<td>9 Chiropractors admitted or readmitted after Rules come into force</td>
<td></td>
<td></td>
<td>Ditto</td>
</tr>
<tr>
<td>10 Chiropractors affected by exceptional circumstances</td>
<td></td>
<td></td>
<td>Assume that similar consideration of exceptional circumstances would need to take place with a new scheme although with three year elements these might be capable of being accommodated with little change given the greater length of time.</td>
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<tr>
<td>11 Service of notices</td>
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<tr>
<td>11. Any summary sheet, demand, warning or notice to be given by the Registrar under these Rules may be sent by post to the address of the chiropractor concerned which appears in the register pursuant to section 6(1)(b) of the Act, and shall be treated as sent or issued at the time of its posting.</td>
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</tbody>
</table>
To: The GCC Council  
From: Penny Bance, Director of Education, Registration and Standards  
Subject: Review of the Code of Practice and Standard of Proficiency (CoP and SoP) and development of guidance  
Date: 31st March 2015

Purpose

1. The purpose of this paper is to update the Council on the review of the Code of Practice and Standard of Proficiency; and
2. to propose topics for separate, more detailed guidance to be developed and published during 2015/2016.

Introduction

3. The Code of Practice and Standard of Proficiency (CoP and SoP) have been in use since 30th June 2010 and since that time the regulatory and healthcare landscape has evolved at a great pace and continues to do so.
4. Recently several healthcare regulators have, or are in the course of, reviewing their Codes. The GDC and the NMC have both revised their Standards and the HCPC Council will shortly be discussing their revised Standards ahead of a public consultation. The GPhC and GOC have just commenced reviews of their respective Codes, and the GOsC will be reviewing its Standards next year.
5. At a meeting with Department of Health officials in December 2014 the GCC’s proposed approach for its new Code - to state patient expectations followed by clear standards using the word ‘must’ to indicate a requirement - was welcomed. The GCC was told that the Department of Health expected professional people to provide safe, effective, compassionate and caring treatment of a high standard to patients, and that the standards being proposed would help the profession deliver this and ensure the profession’s credibility. The need for the GCC to be in line with other healthcare regulators was also reinforced during a meeting between the GCC’s CEO and the Minister as well as at the above-mentioned December meeting with officials.

The Process

6. The review of the CoP and SoP started in late September 2013. Over the course of the review evidence and comment has been gathered from a wide variety of sources. The consultation was conducted by an on-line survey and
four focus groups were arranged during September and October 2014. Full details of the consultation process are provided at Appendix A.

7. The project has involved a mixture of both qualitative and quantitative research methods, registrant and stakeholder engagement, targeted qualitative research in addition to consultation. Extensive pre-consultation work involved engagement with a wide range of stakeholders. Feedback was sought on the draft standards prior to consultation and changes suggested by registrant members of Council were incorporated. The GCC has sought to take a balanced view on all the feedback received throughout the course of the review.

8. Throughout the project the Education Committee and the Council have been updated on the progress of the review and have agreed the direction and timeframe for the work.

Draft Code, consultative version (Version 3, summer 2014)

9. A draft Code was prepared as a more cohesive single document with a cleaner format. This was renamed ‘The Code: Standards of conduct, performance and ethics for chiropractors’ (Appendix B gives fuller information).

10. The aims of this revised version were to:
- present a clearer Code within a new layout/structure and format blending the Standards and Code into one document;
- set out eight high level, equally important Principles that chiropractors would be expected to display publicly in their practice and which would demonstrate, much as other healthcare regulators’ equivalent Codes do, that patients are the chiropractor’s first concern;
- list a set of standards underpinning each Principle, which are further amplified through ‘supporting statements’;
- provide greater clarity and avoid misinterpretation with each Standard (and supporting statement) being obligatory as indicated by being preceded with the words ‘you must’ to indicate a duty to comply1 (this approach was influenced by a direction given by the Professional Standards Authority);
- continue to provide Guidance but this being given separately and not within the document;
- provide a set of ‘patient expectations’ for each Principle;
- Remove references to sources and links to websites from the Code itself, but retain these on the GCC website as a tool to which people can refer. This approach will allow these to be easily updated as, and when, necessary. The glossary is retained. In the main the intention will be for

1 As discussed later in this document this does cause some concern. However, the guidance that was incorporated into supporting statements was largely composed of sentences that were already couched in mandatory terms. A7.2 is one such example.
users to refer to an Adobe pdf document which will provide simple and quick search tools. Therefore the Index is no longer necessary;

- Re-order the majority of the elements of the current Code and Standards to create a total of thirteen new Standards. Three standards would be removed (C7, E9 and F4), which are mainly to do with the business of running a practice);

- revise the content and tone of the introduction; and

- to harmonise and reflect changes required by the Department of Health and capture the tone, tenor and look of the changing healthcare environment (for example, post Francis).

11. The draft version was issued for consultation via an on-line survey and four focus groups during September and October 2014. Full details of the consultation process are provided in Appendix A.

Effect of an alleged breach of the Code

12. As Council was previously advised, a High Court case (Spencer) made it clear in 2012 that unfitness to practise proceedings should only be taken against a registrant of any healthcare profession where the allegation amounted to one of serious incompetence and/or moral blameworthiness. An alleged breach of the Code of Practice would be a starting point only in determining whether or not a registrant was seriously incompetence and/or morally blameworthy. A finding that a chiropractor was in breach of the Code would not mean that there was an automatic finding of unfitness to practise.

Conclusions and recommendations for Version 4 (January 2015)

13. Results from the rating questions alone indicated positive overall satisfaction with the revised Code and this was supported by specific feedback from the focus groups, email and survey responses. This all pointed to largely common and consistent feedback indicating necessary change:

- Format and layout – the feedback suggested this needed to be changed to either have supporting statements immediately under the standard and grouped or shortened as much as possible. The standards have therefore been expanded and the supporting statements removed.

- The Introduction warranted reviewing to ensure it is clear about whom the main user should be and the purpose of the document. Whilst the intention is to be more positive and for the tone of the document to focus on the patient-in other words to put the patient first - it makes sense to ensure that the Code makes it absolutely clear that it sets out standards for the Chiropractic profession.

- There was negligible comment on the eight Principles, suggesting that these work well. (A couple of respondents pointed to overlap and duplication. This does occur naturally, for example, when communicating about matters of consent where we have retained the Consent Principle rather than incorporating it into the Communications Principle.)
• The proposal that ‘References’ to useful information be taken out of the Code to allow for regular updating as required and set somewhere relevant on the GCC website met with general approval.

• No-one disagreed with or commented on the new title suggesting that this was accepted.

• The use of standards and supporting statements being introduced by ‘you must’ - i.e. the obligatory nature - prompted some concern. Although the current 2010 Code and Standards all start with the same stem of "you must" (or this phrase was incorporated within the standard), the guidance explained, and allowed for, greater scope through language such as ‘you might consider’ or ‘it is good practice to’. ‘You must’, however, makes it clear that these are not optional requirements and are expected standards of chiropractors. It was also noted that other leading healthcare regulator (e.g. GMC, GDC) continue to structure the requirements of their respective codes of practice around the use of the phrase ‘you must’.

14. Version 4 was discussed by the Education Committee at a workshop on 30th January 2015. Feedback indicated that this version was a vast improvement, clear and succinct with a strong patient focus.

Considering the above, changes have subsequently been made to arrive at Version 5 (Appendix D) for discussion by Council:

- “About Us”: making it clearer about the outcome should a chiropractor be removed from the register.

- The Introduction: More clarity has been given to the role of Guidance explaining that its intention is to be of help to registrants, and that it will regularly be updated and replaced, thus emphasising the necessity for its regular review.

- Patient expectations: there has been some tightening of the wording and a brief explanation has been included of how these expectations were derived.

- Principles – comments made during the Education Committee meeting has resulted in the removal of areas of ambiguity to improve and clarify wording.

- Glossary —we have added the term carer/representative and have also made word changes to existing items found in the glossary (assessment, diagnosis, delegation and must).

Guidance

15. The Code will be underpinned by guidance that will help registrants understand and inform their actions. The GCC may need to provide supplementary material on such subjects as:

• issues that are relevant to all healthcare professionals, such as consent, duty of candour and maintaining sexual boundaries (often in response to a direction from Government or the Professional Standards Authority);
legal requirements which are complex or confusing in nature, e.g. record keeping;
issues arising persistently in Fitness to Practise cases; and
give clarity in certain circumstances such as the use of social media.

16. Building on the recommendations from the Williams’ Fitness to Practise 2014 report, guidance produced by other healthcare regulators and discussions during the summer consultation, it is proposed that guidance be developed on the following during 2015/16:

- sexual boundaries
- consent (and communication with patients)
- candour (perhaps with complaints and raising concerns)
- confidentiality (including patient data/records),
- using social media
- advertising.

17. The need for additional guidance will be monitored and kept under review. It is proposed that the commissioning of any new or revised guidance will need to meet the following criteria:

- Guidance which is necessary to meet public protection needs
- Guidance must relate directly to the Code
- Guidance must be proportionate and in line with PSA principles on ‘right touch’ regulation.
- Where relevant and appropriate we will seek to develop guidance in conjunction with other regulators.

18. Guidance will be developed and consulted upon prior to approval by Council.

19. A guidance note will be limited to no more than two pages and contain links or references, as appropriate.

20. Guidance documents will be available online and will provide links to further relevant information. This will offer flexibility in relation to the new standards and will mean that the GCC is able to react to any changes that may be made to regulation or legislation without having to review the standards.

21. 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. This will be made clear when guidance is published.

Financial Implications

22. There are financial implications covering the external research, development and consultation of each guidance note of £1000 per area of guidance (a negotiated discount from £1500) plus 2 days @ £500 to develop/agree the template and consult with legal advisor on issues arising from all the areas of guidance. Total costs are estimated as £7000.

23. If, however, the guidance was then to include actual, existing examples/case studies of best practice (rather than a sentence that says – you might want to
consider this or do that), that would have an impact on that estimate as it would take longer to produce.

Equality Implications

24. Equality and diversity issues have been considered throughout the review project and an equality impact assessment will be carried out ahead of Council’s approval of the Code in June to identify any equality and diversity issues that may arise from the introduction of the Code.

Communications Implications

25. A communications and implementation plan will be developed for the new Code.

Action required

26. The Council is asked to

• note the update;
• approve the Version 5 in principle barring any final amends; and
• approve the proposals and costings for the production of guidance notes over the forthcoming year.

Contact

Penny Bance, Director of Education, Registration and Standards

p.bance@gcc-uk.org
Appendix A

Consultation Process (2014)

For respondents to the survey (not just registrants, but also the public, patients and education providers, and students, among others), some background and further information about the review was provided (http://www.gcc-uk.org/good-practice/). A brief summary documenting the changes leading to the new-look Code (draft Version 3.0) was also provided as part of the survey documentation (see Appendix C).

Four focus groups (FG) were organised for September and October 2014. Attendees at each group were presented with the same information on the rationale for, and background to, changes made. Some two hours were allowed for detailed review and feedback. The four focus groups (held in York, Bournemouth, London and Bristol) attracted a range of attendees – mostly practising Chiropractors (a range including those who are new or recent entrants to the profession together with others of many years’ experience), several Association leaders and Education Providers. One student attended the Bournemouth focus group. The attendees totalled just over 70 (York 6, Bournemouth 18, London 23 and Bristol 24).

A meeting was held with representatives of patient groups in December 2014 to discuss and review the patient expectations as to the content of the Code.

The survey ran between 16th September and 31st of October 2014, during which time 307 responses were submitted. The survey was also promoted to focus group attendees, so there is a reasonable chance that some survey respondents were due to, or had already, attended a focus group.

The questions asked at the focus groups were, in order to acquire more in-depth insights into the issues, very similar to the survey questions, which covered the:

1. Introduction section of the draft revised Code and Standards.

2. Clarity of the draft revised Code and Standards in what it requires of chiropractors.


Two open questions provided an opportunity for respondents to comment on the additional/new Standards and add other final comments.

As an email address was provided, some respondents took advantage of the opportunity offered in the survey of sending back the draft Code with tracked changes and comments. Six sets were received in this form.

Findings

Nearly 90% of the 307 survey respondents are practising chiropractors, with the remainder split between a small number of other respondent types including patients (1.3%), chiropractic education providers (2.6%) and chiropractic students (3.6%).

Survey Note: As with all such questions outside detailed academic studies involving pre-qualification tests and interviews, we have no means of calibrating the survey’s main instrument of rating questions, i.e. what would be regarded as a norm reference for the respondents to this survey. Therefore, whilst the mean rating for all three rating questions spanned 6.8 to 7.0, it is not possible to say if these should be regarded as anything other than modest approval: in other words if the respondents to this survey are unlikely to award a rating of 10 or 1. This reduces the rating spread more realistically to be between 2 to 9, which would make 7 a stronger indication of approval.
In our experience and that of the Market Research Society mean scores exceeding seven are generally regarded as good.

**Introduction section of the revised CoP&SoP**

<table>
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<th>Survey Question</th>
<th>Base</th>
<th>Mean</th>
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<tr>
<td>Q4. On a scale of 1 'not at all satisfied' to 10 'very satisfied', how satisfied are you with the Introduction section of the draft revised Code and Standards?</td>
<td>305</td>
<td>6.8</td>
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</table>

The Introduction received little comment in the open responses compared with other sections of the Code.

Across the board there was general acceptance of the direction of change, which was to make the Introduction more positive and remove anything that may no longer be needed (e.g. a definition of Chiropractic and an explanation of the GCC, both of which could be provided on the GCC website).

The focus groups attendees, however, discussed the Introduction at some length; particularly at the last two events (London and Bristol).

One issue discussed at a number of levels was the paragraph:

‘The Code is written to inform the public of what they can expect from chiropractors and to assist chiropractors to uphold the highest standards of care and conduct’

Commentators suggested it would be more appropriate to turn this around (or drop the reference to the public altogether) so that it is clear that the document is intended for Chiropractors as reinforced by the paragraph further down that says:

‘The standards set out ....apply to all chiropractors’.

Similarly, the final paragraph possibly reinforces this confusion as to whom the document is aimed at:

‘This Code should be read in conjunction with our Patient Guide and Explanatory Guidance available from www.gcc-uk.org/publications’

A few focus group attendees were concerned that this implied referring to multiple documents all at once.

A couple of other attendees pointed out that they felt the following paragraph was unclear:

‘Not every standard has supporting statements. Where this is the case, we feel that how you must meet the standard is self-evident or may be supported by our Explanatory Guidance as appropriate’.

Other issues noted by a few focus group attendees or via separate email comment were:

- ‘scope of practice’ – not currently defined, should it be?
- The document perhaps lacks a legal basis which might be deemed necessary to provide the document with more credibility.
The bullet points could do with improvement and ‘underpinning’ is perhaps the wrong word for the Standards.
- The (new) patient expectations possibly warrant some further explanation as to their purpose and status.

**Format/Structure of the revised CoP & SoP (Principles – Standards - Supporting Statement)**

The average rating for satisfaction with the new format was 6.8 (out of 10), which again indicates modest approval among survey respondents.

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<th>Question</th>
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<th>Mean</th>
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<tr>
<td>Q6. On a scale of 1 ‘not at all satisfied’ to 10 ‘very satisfied’, how satisfied are you with the new Principle-Standard-Statement format of the draft revised Code and Standards?</td>
<td>303</td>
<td>6.8</td>
</tr>
</tbody>
</table>

The limited evidence from the survey open question on this subject is ambivalent about the revised format, but only ten respondents provided such responses: Five survey respondents describe it as an improvement but five stated that they preferred the previous format.

It was sometimes unclear, when some respondents referred to the format and structure format, whether they were, in fact, referring to the ‘layout’. A number of comments at focus groups and subsequent discussions revealed that many liked the 2010 layout (with a Standard in one column and relevant Guidance in the accompanying column).

A group at one of the focus groups questioned the need for both the standard and supporting statement, pointing to some instances where the supporting statements did not appear to add value. They suggested either combining the standards and supporting statements or grouping all supporting statements as one standard in one paragraph.

Attendees at one focus group suggested that it would be better to use ‘you must’ as a lead-in platform statement rather than repeating it for every standard. Along that same theme, another focus group attendee suggested that the approach used by the Chartered Institute of Physiotherapists might be a better alternative to using ‘you must’ — their approach is to use the imperative within each of the standards. One example might be: ‘Deliver services that are of value to an individual, supported by evidence of their effectiveness’.

He argued that this had largely the same effect. However, we felt that the single platform statement - “You must:” preceding all standards — even if written in the imperative, is essential to underline the responsibility of the individual professional to meet the standards.
**Clarity of the revised CoP&SoP**

The mean rating for the clarity of the document with respect to what is being asked of chiropractors was 7.0, which again is an indicator of moderate-to-good levels of approval from survey respondents.

<table>
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<tr>
<th>Question</th>
<th>Base</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. On a scale of 1 ‘not at all clear’ to 10 ‘very clear’, how clear is the draft revised Code and Standards in what it requires of chiropractors?</td>
<td>304</td>
<td>7.0</td>
</tr>
</tbody>
</table>

Among the 127 (41%) respondents who went on to answer an open question on the subject, clarity was an important topic drawing forth a range of distinct types of response. On occasion it was difficult to assess whether the responses provided were meant as approval or disapproval, and so these findings should be read with that caveat in mind2. A number of respondents who gave a high rating for clarity overall went on to provided an open response. This suggested that certain respondents were largely happy with the revised CoP&SoP, but had, perhaps, some relatively minor concerns or requests for change.

Within the diverse comments about clarity, the following considerations were common:

- Clarity throughout the CoP&SoP is an important goal;
- Readers of the CoP&SoP must feel that the phrasing is sufficiently detailed if the document is to be clear and usable; and
- Phrasing must be thought through carefully so that it is not unclear and in danger of misinterpretation or creating unnecessary legal issues or barriers to any future fitness to practise cases.

It was also interesting to note that a number of standards that had been taken unchanged from the current CoP&SoP were then subsequently questioned in the consultation.

**Additions to the CoP&SoP**

Some thirteen standards and supporting statements have been introduced into the revised CoP&SoP and therefore were not present in the 2010 version.

These were introduced as outcomes of reviews of the Candour Working Group activity, other Healthcare regulators Standards, the European Standard and the Williams’ Fitness to Practise 2014 report. Respondents were invited to comment upon these as much or as little as they wished. Just over a third (35%) of respondents gave a direct response about ‘additions’ to the draft.

The open responses included comments on standards and/or supporting statements mentioned only by a single survey respondent. However, there were a number of examples of additions to the CoP&SoP that were discussed repeatedly.

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2 Several responses discuss individual standards/supporting statements within the CoP&SoP draft but do not state whether these issues are illustrations of the overall clarity of the draft or a lack of clarity.
Although the following were only mentioned by a minority of survey respondents, they were the most frequent comments on new standards and/or their supporting statements:

B3.2 (2 separate statements taken directly from the European Standard and put together):

B3.2  
Not treat the patient unnecessarily and be able to clinically justify decisions to continue care. When care can no longer be justified on the basis of clinical need or response to treatment, you have a duty to discharge or refer the patient without delay.

- Twelve comments were received about B3.2 with most asking for clarity about what counts as “clinical need” and some suggesting that the CoP&SoP should allow treatments to maintain health as well as respond to symptoms. There was also a number of respondents who preferred to use the phrase “care and treatment” with others preferring “care” instead of “treatment”.

“Point B3.2 I have concerns re the interpretation of the phrase clinical need. This has the potential for problems of definition and interpretation” – Chiropractor

E5.1 (words taken directly from Guidance in B4, GDC and a F2P issue)

E5.1  
Treat consent as a continuing process, not a one-off event. It is an integral part of effective and on-going communication between patients and all those responsible for their care. You must gain consent for what you are going to do for each appointment when carrying out an on-going course of treatment.

- This received eleven comments, most of which stated that it is excessive to require consent at every visit.

“E5.1 states that you need to "gain consent...an on-going course of treatment” I have several issues with this statement, gaining consent for every visit is impractical and as a patient I would also find it annoying.” – Chiropractor

The issue of ‘consent’ came up at most of the focus groups and also within email responses and not always just in the context of E5.1. One respondent, for example, mentioned that the main Principle of E should be re-worded to read ‘fully informed’ consent.

G2 – (taken from GDC)

G2  
You must provide good quality care based on current evidence and authoritative guidance
G2.1 Ensure that your clinical practice incorporates the best available evidence from research, your own expertise (and of other practitioners as appropriate) and the preference of the patient.

G2.2 Be knowledgeable about underlying theories of the care you provide and be competent to apply it in practice. Your provision of care must be evidence-based.

- A total of 15 respondents commented on this Standard and/or its supporting statement, of which seven people requested clarity about what counts as “authoritative guidance” in G2 with others being very concerned about the phrase ‘current evidence’ particularly as they felt that ‘G2.2..provision of care must be evidence-based’ contradicted G2.1.

Other ‘new’ standards prompting comments were:
- Regarding justification for X-Rays being recorded (A10) – it was pointed out this is not necessary and goes beyond the legislative requirement.
- Some standards were felt unnecessary as they were covered by existing legislation and that reference to the appropriate legislation should be sufficient – e.g. A6.
- B1 – duty of candour – two focus groups were fortunate to hear about the outcomes of the discussion the GCC had with insurance companies. This helped to alleviate some of their concern. It was generally agreed that the seven supporting statements should be reduced in number.
- B11 – it was questioned whether this was sufficiently clear and if ‘abuse’ was the right term here? (‘…abusing the regulatory process for furtherance of commercial ends…’)
- D5 and its use of the word ‘close’ in the context of an improper emotional relationship prompted a number of queries and comment.

Final Comments about the revised draft CoP&SoP overall

After being asked about the additions to the CoP&SoP, respondents were invited to share their final, overall opinions about the draft.

In total, 28% of respondents took that opportunity to respond or make comment. The responses largely fell into the following categories:

- Issues that are one-off items or are outside the remit of the consultation, such as the concept of one CoP&SoP across some or all of the healthcare regulators (15).

- Ease of use – points of clarity (22). Respondents wanted clarity of meaning, better phrasing or suggested there was scope to remove repetition or complexity (e.g. A1 and A1.1/A1.2 – are both A1.1 and A1.2 required – could they be combined with the Standard?).

- Concern regarding intended meaning and the danger of misinterpretation (18). (e.g. D2 or A7)

3 A1. You must ensure that you listen to your patients, acknowledging their views and respecting their decisions. A1.1 and A1.2 - Talk to your patients and encourage them to talk to you to enable each patient to play a full part in their own assessment and care. (A1.2) Listen to patients and communicate effectively using a means that they can understand
4 A1. You must offer a gown to all patients and have them available for patients to use.
5 ‘..put patients interest before your own..’
- The use of ‘must’ – making standards and their supporting statements obligatory (15 responses although this was the basis of many concerns). Respondents’ issues, in the main, described situations where they worried that the wording was too stringent, and either suggested using phrases such as “where reasonably practicable” or they described exceptional circumstances which warranted recognition (e.g. D1 – treatment of spouse could prove awkward or C11.1 where the CE mark is not relevant).

Open response feedback taken together
Overall 41% of survey respondents (127) responded to either one or both of the open questions Q7 and Q8, of which over 20% of that 127 gave the document a positive final comment such as:

'It appears to be an efficient and pragmatic document with a clear balance in favour of the patients well being.' – Education provider

'A real improvement on the old Code, thank you'. – Chiropractor

An additional 7% of that same base of 127 gave a positive comment, but with a caveat about wording they would prefer to see being changed or clarified.

The majority of that base of 127 (73%) used the open questions to provide detail on standards and or supporting statements they wanted to query, comment on and/or have changed.

Emerging from that set of feedback were comments that were referred to or mentioned more than once and are mentioned here as they have not yet been raised.

These are issues that were also discussed at the focus groups:

- Length of time for keeping health records – guidance on this may well be necessary given it is a complex area and depends on many factors such as age and type of record. Legislation can be contradictory in their requirements (A10.2)

- The use of titles (B7 and B7.1) prompted a number to respond about this whole topic.

- H3 and H3.5 with regard to improper disclosure of patient’s personal information, e.g. when selling a business.

- When does someone who is receiving care even if informally become a patient?

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6 D1 ‘You must not have a sexual relationship with any patient or their carer’ and C11.1 ‘Ensure all medical devices you use carry the CE mark …’.
Appendix B: Summary of Changes made to the Draft Revised Standards (as of
July 2014)

A number of high level principles were discussed at the meeting with the GCC on 28
April 2014 and a provisional list of nine principles was agreed on 16 May 2014.
Following that, Pye Tait prepared two mock-ups of one principle to establish
preferred format and style for the new Standards and have since undertaken work to
formulate the full draft principles and standards in the agreed format. This work
involved close consultation of:

- The existing CoP and SoP;
- The standards of other healthcare regulators that are, or have been, recently
  under revision - NMC, GDC;
- The CEN European Standard for ‘Healthcare provision by chiropractors’ with
  particular attention on Code of Ethics contained within;
- The independent review of GCC Fitness to Practice Cases 2010-2013
  undertaken by Sally Williams;
- On-going developments in healthcare policy around candour, consent and
  complaints.

Changes made and rationale

- We have re-organised the Principles into a more logical order. In doing so, we
  have;
  o ensured that the patient, their interests and information is placed first,
    in accordance with the ethos prevailing across healthcare that patient
    safety is top priority;
  o led that into issues around consent and communication which are
    closely linked;
  o grouped professional boundaries, behaviour and skills/knowledge
    together;
  o placed the more ‘personal behaviour-oriented’ principle last so that it
    will have lasting impression on readers.
- We have merged the Principles *Keep your professional knowledge and skills
  up to date* and *Work within the limits of your professional knowledge and
  skills*. Other regulators, with the exception of NMC, do not separate these two
  areas. There are only two existing standards in the COP and SOP and this is
  an area that work is ongoing, and so may be subject to development.
- For each principle, we have begun with a short paragraph, setting the scene
  and highlighting the importance of and philosophy behind each Principle. This
  text is largely re-written from the COP and SOP, although some wording has
  been taken from the CEN standard (e.g. Principle D) and other regulators.
- Using other regulators’ standards, particularly GDC’s Standards for the
  Dental Team, alongside GCC’s, ‘What can I expect when I see a
  Chiropractor?’ patient leaflet, and Guidance notes in the existing COP and
  SOP, we have formulated a series of Patient Expectations for each Principle,
  to set the context and rationale for the ensuing standards.
- In working up the standards for each Principle we have;
  o Used existing standards from the COP-SOP, either verbatim or
    modified so they are clearer, crisper and include ‘must’ as appropriate;
  o Re-ordered those standards to sit more logically within the new
    Principles;
  o Created new ones (see new B10, C5, C6, D9, E2-E4, F6, F7, G7 and
    H1)
Appendix C: Changes summarised for the On-line Survey for information to participants

In summary, the proposed changes are:

1) Rather than a Code of Practice followed by Standard of Proficiency, there will now be a single cohesive, and shorter, document. A more concise Introduction simply reinforces the role and purpose of The Code, which is to protect patients and serve the profession through setting core ethical principles of practice and standards of conduct and behaviour to which chiropractors registered with the GCC must adhere.

2) There is no longer any ‘guidance’ within the document, although it is anticipated that separate guidance will be produced on specific aspects. The removal of guidance within the document was partly to overcome any inference that some aspects of the document were mandatory and some voluntary.

3) The Code is structured differently than before:
   a. It contains eight principles - in no particular order:
   b. Every principle has a short summary of what patients should expect regarding that aspect of chiropractic,
   c. Every principle contains a number of Standards which are mandatory and therefore must be capable of being met by every registrant. There are 70 Standards in total (see point 4 below),
   d. For most of those Standards there are also clarification statements, and by default these are obligatory as they provide amplification for the mandatory Standards.

4) We have introduced circa thirteen NEW standards.

5) The only standards to have been removed include those on running a business, such as financial records or indemnity insurance, as these were deemed to be out of scope of the remit of the regulator.
The Code

Standards of conduct, performance and ethics for chiropractors.

Effective from 30th June 2016 (to be confirmed)

Draft Revised Version 5.0
About Us

The General Chiropractic Council (GCC) is the regulator for the chiropractic profession in the UK. Our overall purpose is to protect the public and our duty is to develop and regulate the profession of chiropractic.

We do this by setting standards of education for individuals training to become chiropractors, and setting standards of professional conduct and practice for practising chiropractors.

Everyone calling themselves a chiropractor in the UK must be registered with us. To be registered with us, an individual must satisfy the educational requirements for registration and be fit to practise, by which we mean they have the skills, knowledge, good health and character to practise the profession safely and effectively.

We have clear and transparent processes in place for investigating and taking appropriate action against chiropractors who are alleged to be unfit to practise because of incompetent professional performance or unacceptable professional conduct. A serious failure to follow this Code and Guidance issued by us could see a chiropractor removed from our register and be unable to practise as a chiropractor in the UK.

Professionalism is an integral theme throughout the Code for standards of conduct, performance and ethics for chiropractors. Professional people provide safe, effective and compassionate care of a high standard to patients. The standards in this Code are intended to help registrants deliver this.

The word “must” throughout the Standards confirms to the profession and informs the public that these standards have to be met. Whilst a chiropractor can interpret these principles and standards in different practice settings, they are not negotiable or discretionary.

It is important to note that this Code should be interpreted by all readers in the spirit it is produced. Where an unintentional or minor breach of a standard has taken place, this will not automatically involve or necessitate a Fitness to Practise investigation by the GCC.

Practising chiropractors are placed in a position of trust; trust which is earned by education, experience and by providing safe, effective and quality care. The provision of chiropractic care in the UK is based on professionalism, trust, honesty and confidence.

Putting patient health interests first is an important principle for professionals and, as a result, promotes and encourages trust. Our Code sets out patient expectations followed by the principles and standards: taken together, these make clear what good chiropractic looks like.
Introduction

This Code, prepared by the General Chiropractic Council\(^1\), sets out standards for conduct, performance and ethics for chiropractors to ensure the competent and safe practice of chiropractic.

The Code specifies the principles and standards applicable to all chiropractors whose duty is to promote the health and wellbeing of their patients. There are eight **Principles**\(^2\) each of which incorporates a number of **Standards** relating to conduct, behaviour and ethics, all of which chiropractors must practise.

The Code has two purposes: its primary purpose is to help chiropractors uphold the highest standards of care and conduct, but its other purpose is to make clear the quality of care that patients should reasonably expect from registered chiropractors. The section on **Patient expectations** aims, therefore, to help patients with their understanding of, and expectations for, chiropractic.

When joining the register, and subsequently renewing their registration, chiropractors commit to upholding these standards – a fundamental requirement to being part of a regulated profession.

Every registrant has a responsibility to meet these standards and apply the ethical principles whilst placing the health and wellbeing of their patient at the centre.

**Guidance**

The GCC produces separate, supplementary Guidance for the purposes of providing helpful and constructive advice for registrants in implementing the Code. The Guidance is not exhaustive and will be updated.

Such guidance is on the GCC website at [www.gcc-uk.org/publications](http://www.gcc-uk.org/publications).

In order to keep themselves up-to-date, as required by the Standards, registrants must review and refer to the Guidance on a regular basis.

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. This will be made clear when guidance is published.

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1. As required by the Chiropractors Act 1994. The Code encompasses both a standard of proficiency and standards of conduct and practice.
2. The eight principles are of equal importance and are not listed in any order of priority.
Patient and public expectations of registered chiropractors.

Patient understanding and involvement in their own care is a key underpinning of professional conduct by chiropractors.

Patients should reasonably expect you to:

- Listen to them and take their preferences and concerns into account.
- Treat them as individuals with dignity and respect for their culture and values.
- Be trustworthy and responsible and protect them from harm.
- Make reasonable allowances for any disability.
- Consider all aspects of their health and wellbeing and give them the care that is appropriate to them.
- Care for them in a clean and safe environment.
- Put their health and welfare interests first.
- Ensure you and all other chiropractors you employ are properly qualified, registered and insured.
- Be honest with them and act to resolve issues accordingly if something goes wrong.
- Cease care if asked to, or if this is in their best interests, give valid reasons for discontinuing or refusing care.
- Provide them with guidance and advice about other forms of care where necessary.
- Only recommend care based upon the best available evidence and that meets their preferences.
- Carry out any assessment or administer care, as required, following examination and evaluation.
- Review and re-assess the effectiveness of care plans, and give feedback about the care they receive.
- Make clear who is responsible for their overall and day-to-day care and of any part that has been delegated, explaining the arrangements if you are unavailable.
- Have systems in place that ensure a competent and high quality service.
o Follow current professional healthcare guidance on sexual boundaries and not breach them.
o Ensure the focus of your professional relationship is on meeting their health needs.
o Provide full, clear and accurate information before, during and after care so that they can make informed decisions.
o Present information about assessment and care options available to them in a way that is easy for them to understand and use.
o Explain clearly what they can expect from care, the likely outcomes and any risks or benefits.
o Ask for their consent to care before it starts.
o Always ask for their consent for you to adjust or remove items of their clothing if this is necessary for examination.
o Seek their consent before sharing personal information with third parties if it becomes necessary as part of your professional responsibilities.
o Listen and act upon any complaints they might have.
o Provide good standards of care based on evidence and best practice.
o Work within your professional competence and abilities.
o Refer to or seek expertise from other chiropractors and healthcare professionals, where appropriate.
o Maintain and update your professional knowledge and skills throughout your working life as a registered chiropractor.
o Ensure their records are up to date, complete, clear, accurate and legible.
o Keep their personal details confidential.
o Store their records securely but make their records accessible to them where required as prescribed in law.
o Inform them of any breaches of confidentiality.
o Adhere to GCC standards and to regularly read all GCC Guidance.
Principles. As a chiropractor you must:

A  Put the health interests of your patients first
B  Act with honesty and integrity and maintain the highest standards of professional and personal conduct
C  Provide a good standard of clinical care and practice
D  Establish and maintain a clear professional relationship with patients
E  Obtain informed consent on all aspects of patient care
F  Communicate properly and effectively with your patients, colleagues and other healthcare professionals
G  Maintain, develop and work within your professional knowledge and skills
H  Maintain and protect patient information
PRINCIPLE A - Put the health and welfare interests of your patients first

You must put the patient’s health first, respect them and ensure you promote their health and welfare at all times. You must take account of these factors when assessing them, making referrals, or providing or arranging care.

Standards (A)

You must:

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.

A2 respect patients’ privacy, dignity and cultural differences.

A3 take appropriate action if you have concerns about the safety of a patient.

A4 treat patients fairly as individuals and without discrimination.

A5 prioritise patients’ health and welfare at all times when carrying out assessments, making referrals or providing or arranging care.

A6 treat patients in a hygienic and safe environment.

A7 safeguard the safety and welfare of children, young people and vulnerable adults. Adhere to legislation and follow local procedures if you suspect a child, young person or vulnerable adult is at risk from abuse or neglect.
PRINCIPLE B – Act with honesty and integrity and maintain the highest standards of professional and personal conduct

You must act with honesty and integrity at all times and uphold high standards of professional conduct and personal behaviour to ensure public confidence in the profession. You must be guided in your behaviour and practise at all times by the principle that the health and well-being of a patient comes first. You must follow procedures set down by the regulator.

Standards (B)

You must:

B1 protect patients and colleagues from harm if your health, conduct or performance, or that of a regulated healthcare professional, puts patients at risk.

B2 ensure you, and any chiropractor you employ, are properly qualified, registered and insured.

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 advertising codes and legislation.

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.

B5 ensure your behaviour is professional at all times thus upholding and protecting the reputation of the profession and justifying patient trust.

B6 not charge for any additional care than a patient actually needs; avoid placing any undue financial pressure on a patient.

B7 in accordance with the duty of candour, exercise your professional duty to be open and honest with patients and 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 and an appropriate remedy or support if this happens.

B8 justify and record your reasons for either refusing care or discontinuing care for a patient. You must explain, in a fair and unbiased manner, how they might find out about other healthcare professionals who may be able to care for them.

B9 follow proper procedures for informing the GCC if you are subject to criminal proceedings or a regulatory finding has been made against you anywhere in the world. You must cooperate with the GCC when asked for information.
PRINCIPLE C – Provide a good standard of clinical care and practice

You must uphold the high standards of the chiropractic profession by delivering safe and competent care to each patient. This applies to all aspects of clinical practice and patient care.

Standards (C)

You must:

C1 obtain and document the case history of each patient, using appropriate methods to draw out the necessary information.

C2 when carrying out a physical examination of a patient use diagnostic methods and tools appropriate to the patient giving due regard to the patient’s age, health and dignity. You must document the results of the examination in the patient’s records and fully explain these to the patient.

C3 use the results of your clinical assessment of the patient to arrive at and document a working diagnosis or rationale for care. You must keep the patient fully informed.

C4 develop, document and apply a plan of care in full agreement with the patient. You must check the effectiveness of the care and keep the plan of care under review. A more formal reassessment of the effectiveness of the plan of care must be undertaken at intervals appropriate to the patient. All subsequent changes or modifications to the plan of care are discussed and agreed with the patient and properly documented.

C5 select and apply appropriate evidence-based care which meets the preferences of the patient at that time.

C6 cease care if, on review, or at any time, it is in the patient’s best interest to stop. You must cease care, or aspects of care, if you have been asked to by the patient or if your care has not been as effective as you had anticipated in the given time frame. You must refer the patient to another healthcare professional if appropriate.

C7 follow appropriate patient referral procedures when a patient has been referred to you; this must include keeping the healthcare professional making the referral being kept informed of the outcomes of your findings. You must seek 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. Such investigations must be consented to by the patient. You must adhere to Ionising radiation (Medical Exposure) (Amendment) legislation and regulations and record the rationale for, and outcomes of, any such
investigations.

C9  ensure all equipment used in your practice is safe and compliant with relevant legislation.
PRINCIPLE D – Establish and maintain a clear professional relationship with patients

The professional relationship between a chiropractor and a patient depends on confidence and trust. It is your duty to not undermine that confidence and trust.

You must establish and maintain clearly defined professional boundaries between yourself and your patient to avoid confusion or harm and to protect the welfare and safety of the patient and/or their carer.

Standards (D)

You must:

D1 not abuse your position of trust and professional position and harm patients and/or their carers by crossing sexual boundaries.

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 when assessment or care might be considered intimate or where the patient is a child, young person or a vulnerable adult.
**PRINCIPLE E – Obtain informed consent for all aspects of patient care**

Patient consent must be voluntary and informed and it is your duty to ensure the patient has all the necessary information and support they need in order to give it. You must ensure that, when the circumstances of a patient’s care changes, ongoing consent is obtained.

**Standards (E)**

**You must:**

E1 share with the patient accurate, relevant and clear information to enable the patient to make informed decisions about their health needs and relevant care options. You must also take into consideration a patient’s capacity to understand.

E2 obtain and record consent from a patient, or their representative, prior to starting that care and to the plan of care itself.

E3 check with the patient that they continue to give their consent to assessments and care.

E4 ensure the consent of a patient is voluntary and not under any form of pressure or undue influence.

E5 seek parental consent first if a child or young person is to be seen without someone else being present, unless the child or young person is competent to make their own decisions. See legislation.

E6 always obtain a patient’s consent if it becomes necessary for the purposes of examination during care, for you to adjust and/or remove items of the patient’s clothing.

E7 seek and record the express consent from the patient (given orally or in writing) regarding sharing of their patient record. You must not disclose personal information to third parties unless the patient, or their representative, has given their prior consent for this to happen.
**PRINCIPLE F – Communicate properly and effectively with patients, colleagues and other healthcare professionals**

The relationship between a chiropractor and a patient is built on trust, honesty and confidence. You must communicate effectively with patients in order to establish and maintain an ethical relationship and encourage them to take an informed role in their care.

**Standards (F)**

**You must:**

**F1** explore care options, likely outcomes, risks and benefits with patients, encouraging them to ask questions. You must answer fully and honestly.

**F2** have visible and easy-to-understand information on patient fees, charging policies and systems for making a complaint. These policies must include the patient’s right to change their mind about their care, and, refer any unresolved complaints to the GCC.

**F3** involve other healthcare professionals in discussions on a patient’s care if this means the possibility that a patient’s health needs will be met more effectively.

**F4** take account of patient communication needs and preferences.

**F5** listen to, be polite and considerate at all times with patients including regarding any complaint that a patient may have.

**F6** provide information to patients about all individuals responsible for their care, distinguishing, if appropriate, between those responsible for delegated aspects and for their day-to-day care. This must include the arrangements for when you are not available.
PRINCIPLE G – Maintain, develop and work within your professional knowledge and skills

As a healthcare professional you are required to use your professional judgement to recognise and work within the limits of your own knowledge, skills and competence to ensure patient safety and protect the reputation of the profession.

To assure your continuing fitness to practise you must maintain and develop your professional knowledge, skills and performance in accordance with the requirements set out by the GCC.

Standards (G)

You must:

G1 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance.

G2 Maintain your knowledge, making sure it is up-to-date and accurate.

G3 recognise and work within the limits of your own knowledge, skills and competence.

G4 make clear the limits of your competence and knowledge to patients.

G5 refer to, or seek expertise from, other chiropractors or healthcare professionals, where appropriate.

G6 not require anyone else to take on responsibilities for patient assessment and care where it would be beyond their level of knowledge, skills or experience.
PRINCIPLE H – Maintain and protect patients’ information

It is your responsibility to maintain and protect the information you obtain directly or indirectly in the course of your work. Confidentiality is central to the relationship between chiropractor and patient. The records you keep must be an accurate reflection of the clinical encounter and must include any factors relevant to the patient’s ongoing care, including their general health.

Standards (H)

You must:

H1 keep information about patients confidential and avoid improper disclosure of their personal information.

H2 ensure your patient records are up-to-date, legible, attributable and truly representative of your interaction with each patient.

H3 ensure the safe storage of patient records so that they remain in good condition and avoid inappropriate access. Storage should be for at least a period relevant to the age of the patient as prescribed in law.

H4 make proper arrangements if you close down your practice or in the event of your death. You must notify the GCC of the arrangements you have made. Make sure that patient records remain your responsibility, even where a patient has moved, unless you have contractually transferred this responsibility to another healthcare professional or organisation.

H5 only disclose personal information after having sought patient consent if it is required in the public interest and is carried out in accordance with legislation.

H6 give patients access to their personal health records as required by legislation.
Glossary of terms

Capacity  Ability of a patient to understand, remember and consider information provided to them. Note: The legal framework for the treatment of a child or young person lacking the capacity to consent differs across the nations of the UK. It is important you operate within the relevant law that applies in the nation in which you are practising.

Care  Interventions by chiropractors that are designed to improve health, covering: promoting health, maintaining health and preventing ill health, and addressing health needs. The methods that might be used include:

- manual treatments
- the use of other technologies – for example, ultrasound, traction, relaxation exercises, applying hot and cold packs, dry needling
- advice, explanation and reassurance – for example, explaining the kinds of activity and behaviour that will promote recovery, giving nutritional and dietary advice
- exercise and rehabilitation
- multidisciplinary approaches – for example, making referrals, joint plans of care with other healthcare professionals
- supporting the patient’s health and wellbeing with other carers and stakeholders – for example, relatives, employers
- preventive measures linked to the patient’s lifestyle – for example, eating, exercise, stress management
- preventive measures linked to the patient’s environment – for example, their home, workplace
- promoting health and wellbeing – for example, using behaviour-change approaches.

Carer  A person of any age, adult or child, who provides unpaid support to a partner, child, relative or friend who cannot manage to live independently or whose health or wellbeing would deteriorate without this help.

Case history  Detailed account of a person’s history which results from the acquisition of information through interview, questionnaires and assessment of appropriate medical records.

Chaperone  Person who is present during a professional encounter between a chiropractor and a patient, e.g. relatives, carers, representative or another member of the healthcare team.

Child or young  England, Wales, Northern Ireland and Scotland each
**person** have their own guidance for organisations to keep children safe. They all agree that a child is anyone who is under the age of 18. A young person generally refers to 16 and upwards (see also Capacity).

**Clinical assessment** Chiropractor’s evaluation of a disease or condition based on the patient’s report of their health (that is, their physical, psychological and social wellbeing) and symptoms and course of the illness or condition, along with the objective findings including examination, laboratory tests, diagnostic imaging, medical history and information reported by relatives and/or carers and other healthcare professionals.

**Consent** Acceptance by a patient of a proposed clinical intervention after having been informed, as far as reasonably can be expected of all relevant factors relating to that intervention.

**Continuing Professional Development (CPD)** Means by which members of a profession maintain, improve and broaden their knowledge and skills and develop the personal qualities required in their professional lives. The means will be explained on the GCC website and updated from time to time.

**Delegate** Asking someone else to provide care on a chiropractor’s behalf.

**Equipment** Instrument, apparatus, appliance, material or other article, whether used alone or in combination, including the software necessary for its proper application, intended by the manufacturer to be used for human beings.

**Evidence-based care** Clinical practice that incorporates all or the best available evidence from research, the expertise of the chiropractor, and the preference of the patient.

**Health** A state of complete physical, mental and social wellbeing not merely the absence of disease or infirmity (*taken from the preamble to the Constitution of the World Health Organisation*).

**Investigation** Clinical study which contributes to the assessment of a patient which may include diagnostic imaging technology, examining systems and laboratory testing.

**Local procedures** Arrangements set out, developed and published by local authorities across the UK for the management of referrals and assessments of a child, young or vulnerable person.

**Must** This means that the duty as set out in the standard is compulsory.

**Patient** Individuals who have been given clinical advice or assessment and/or care by a chiropractor.

*The term ‘patient’ has been used to save space and is*
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient confidentiality</td>
<td>Right of an individual to have information about them kept private.</td>
</tr>
<tr>
<td>Patient examination</td>
<td>Clinical assessment of a patient with the intention of reaching or reviewing a rationale for care.</td>
</tr>
<tr>
<td>Plan of care</td>
<td>Plan designed to deliver therapeutic benefit to patients following clinical assessment.</td>
</tr>
<tr>
<td>Record</td>
<td>Document containing personal information and information relating to the clinical assessment and working diagnosis or rationale for care of a patient.</td>
</tr>
<tr>
<td>Referral</td>
<td>Transferring of responsibility for care to a third party for a particular purpose, such as additional investigation, care or treatment that is outside the chiropractor’s competence.</td>
</tr>
<tr>
<td>Representative</td>
<td>A person chosen or appointed to act or speak on behalf of another or others.</td>
</tr>
<tr>
<td>Working diagnosis/ rationale for care</td>
<td>Establishing a logical treatment protocol resulting from clinical assessment.</td>
</tr>
</tbody>
</table>
To: The Council, General Chiropractic Council
From: Paul Ghuman, Director of Resources and Regulation
Subject: Performance Report
Date: 31 March 2015

1. Purpose

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

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 60% of cases have been listed within six months in 2015. This figure will improve during the second half of 2015 when all the backlog PCC cases have been determined at the PCC. The current hearing days allocated for the year are deemed appropriate.

Business Plan

All activities due to be delivered in Quarter 1 are progressing as planned.

Financial Summary

Income

The overall income position at the end of February is that income to date is £2,239k and the forecast position to date is also £2,239k.

However, it should be noted that, annual retention fee income is £18.5k below target. This in percentage terms is a 1% difference. This position is offset by the fact that to date we have received £18.3k more than expected on Initial registration, restoration and investment income figures to date. This leads to a minor difference of 0.2k.
Expenditure

The overall position is that we have spent £10k less than expected at the end of February. The actual spend was £361k against a forecast spend of £371k.

The only negative difference of note is that of FtP costs. There were two Interim Suspension Hearings (cases where it is considered that the committee should consider an immediate suspension in the public interest) in this period. On one occasion where the FtP lawyer advocate was to present a case, we had to instruct external counsel to present this case as we required the FTP lawyer advocate to attend the performance review meeting with the PSA.

There is a reduction in accommodation costs of £25k following new rates being negotiated.

At present, we have not used Professional fees (primarily in relation to legal advice) to the level anticipated to date.

The surplus for the period is £1,878k in comparison to a forecast surplus of £1,868k leading to a positive difference of £10k.

The grant balance from the Department of Health for work on Continuing Fitness to Practice is £72k at the end of February 2015.

Council will note the positive position on both investment income to date and on the portfolio value at the end of February 2015 which was £4.4M. This is an increase of £400k on the initial investment.

3. Action required

Council is asked to note the Performance Report.

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

February 2015

Prepared by the Senior Executive Board/March 2015
## Overview

### Major Events

Professional Standards Authority (PSA) levy – The levy of £6k will now be payable in the first year from August 2015. This has been included in the budget.

PSA initial stages audit of the GCC – Council has received the Initial stages audit report issued by the PSA.

PSA Performance Report 2014/15 – The next stage in this process is that a draft PSA report will be issued for comment in April 2015.

PSA Performance Review – Following a meeting with regulator leads, the PSA are taking a revised version of the performance review to their Council on 18th March. Following agreement, the consultation will be launched on 30 March 2015 for a 12 week period.

Private Member’s Bill – The Bill has reached the Committee stage in the House of Lords. The main impact of this Bill, should it receive Royal Assent, on the GCC would be to amend the statutory objective to read: “The over-arching objective of the Council in exercising their functions under this Act is the protection of the public.” With parliament rising on 30th March, the prospect of this bill receiving Royal Assent is minimal.

### Business Plan delivery

Council agreed that the executive will report on any activity that is not proceeding as planned.

At this early stage in the year activities planned for completion in Quarter 1 are progressing as planned.

### Key Performance Indicators

We are not hitting our target to list 90% of PCC hearings within nine months of referral. This is explained on Page 4.

### Financial

The profit on our investment portfolio has reached £399k. This is a sum available to the Council as a reserve.

The key change on the financial position this year is that we have received less than anticipated retention fee income. This is as a result of an increase in failures to comply with CPD requirements and retirements. These factors have meant that we have received 1% less in income than anticipated which equates to £18.5k. The level of initial registration is higher than expected at this stage. The financial summary is on page 3 and 4.
Financial Summary – As at 28th February 2015 – Month 2 of financial year.

<table>
<thead>
<tr>
<th>Income</th>
<th>Actual</th>
<th>Budget</th>
<th>Difference</th>
<th>Full Year Budget</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Registration</td>
<td>42,400</td>
<td>33,750</td>
<td>8,650</td>
<td>137,250</td>
<td>1</td>
</tr>
<tr>
<td>Non practising to practising</td>
<td>1,600</td>
<td>1,600</td>
<td>0</td>
<td>8,000</td>
<td></td>
</tr>
<tr>
<td>Restoration</td>
<td>5,450</td>
<td>2,250</td>
<td>3,200</td>
<td>7,500</td>
<td>2</td>
</tr>
<tr>
<td>Retention - Practising</td>
<td>2,125,600</td>
<td>2,143,200</td>
<td>-17,600</td>
<td>2,143,200</td>
<td>3</td>
</tr>
<tr>
<td>Retention - Non Practising</td>
<td>29,400</td>
<td>30,300</td>
<td>-900</td>
<td>30,300</td>
<td>3</td>
</tr>
<tr>
<td>Investment Income</td>
<td>34,485</td>
<td>28,000</td>
<td>6,485</td>
<td>168,000</td>
<td></td>
</tr>
</tbody>
</table>

| Income                              | 2,238,935 | 2,239,100 | -165   | 2,494,250 |

<table>
<thead>
<tr>
<th>Expenditure</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Costs</td>
<td>160,118</td>
<td>162,436</td>
<td>2,317</td>
<td>997,114</td>
</tr>
<tr>
<td>IT costs</td>
<td>7,725</td>
<td>10,000</td>
<td>2,275</td>
<td>80,000</td>
</tr>
<tr>
<td>Meeting room costs</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Office Costs</td>
<td>18,637</td>
<td>20,783</td>
<td>2,146</td>
<td>138,500</td>
</tr>
<tr>
<td>Accommodation Costs</td>
<td>38,650</td>
<td>41,960</td>
<td>3,310</td>
<td>268,200</td>
</tr>
<tr>
<td>Finance costs</td>
<td>622</td>
<td>917</td>
<td>294</td>
<td>21,465</td>
</tr>
<tr>
<td>Professional fees</td>
<td>9,157</td>
<td>16,350</td>
<td>7,193</td>
<td>160,000</td>
</tr>
<tr>
<td>Council costs</td>
<td>20,353</td>
<td>20,133</td>
<td>-220</td>
<td>166,800</td>
</tr>
<tr>
<td>Communication</td>
<td>0</td>
<td>1,000</td>
<td>1,000</td>
<td>18,000</td>
</tr>
<tr>
<td>Registrations</td>
<td>1,352</td>
<td>1,500</td>
<td>148</td>
<td>7,000</td>
</tr>
<tr>
<td>Education</td>
<td>1,795</td>
<td>3,605</td>
<td>1,810</td>
<td>25,130</td>
</tr>
<tr>
<td>FtP</td>
<td>102,410</td>
<td>92,458</td>
<td>-9,952</td>
<td>602,000</td>
</tr>
</tbody>
</table>

| Expenditure                          | 360,821 | 371,142 | 10,321 | 2,484,209 |
| Surplus / (Deficit)                  | 1,878,114 | 1,867,958 | 10,156 | 10,041    |

<table>
<thead>
<tr>
<th>Grant Funding - Earmarked for Revalidation</th>
<th>Balance b/f</th>
<th>Income</th>
<th>Expenditure</th>
<th>Balance c/f</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>76,818</td>
<td>0</td>
<td>4,652</td>
<td>72,166</td>
</tr>
</tbody>
</table>
Other Notes

Note 1: The figure for Initial registration is higher than expected. This is as a result of 15 individuals joining the register after 10\textsuperscript{th} November, thereby paying a single fee which effectively covers initial registration and retention to the end of the following year.

Note 2: The figure for restoration is higher than expected. This may reflect individuals who did not apply for retention or at that time did not meet the requirements but are now able to do so.

Note 3: The retention income figures for 2015 are below those forecast by 1%. This leads to a negative variance of £18k. The variable factors are the number of individuals leaving the register each year. This could be, for example, as a result of voluntary removal or non-compliance with CPD requirements.

Note 4: The actual figure for FtP is higher than budgeted at present primarily as a result of 2 unplanned Interim Suspension hearings during the period and using external Counsel in one case. It is expected that these costs will remain within budget by the year end.

Portfolio Valuation

The portfolio valuation is £4,398,837 from an initial investment of £4M.

Key Performance Indicators

<table>
<thead>
<tr>
<th>Fitness to Practise</th>
<th>Status</th>
<th>Exception Information</th>
<th>Change from last report</th>
</tr>
</thead>
<tbody>
<tr>
<td>To list 90% of PCC hearings within nine months of referral</td>
<td>Red</td>
<td>Actual rate - 60% of cases listed in 2015 were within 9 months of referral. The reason for this failure to meet out targets is because of the increased number of referrals to the PCC at the end of 2012 and during 2013. To cope with this the number of hearing days allocated in 2015 remains high. However, we expect the bulge in PCC cases to have worked through the system during the year and we expect to meet our target during the latter half of 2015.</td>
<td>Slight improvement from the last report in which only 50% of cases were being listed within nine months.</td>
</tr>
</tbody>
</table>

Operational plan progress – by strategic aim and activity

Reporting on the achievement of key milestones due for completion by quarter 1.

All activities planned for completion by Quarter 1 are proceeding as planned.
Annual registration report
2014
Report on the 2014 registration year

This report provides an overview of the work undertaken by the registrations department of the General Chiropractic Council (GCC) during the period from 1 January to 31 December 2014.

New Registrants

An overview of 2014 new registrations

In total 179 new registrants joined the GCC during 2014. This was an increase of 23 from 2013, when 156 were registered. The monthly split of new registrants was as follows:

Table 1 – number of new registrants during 2013 and 2014 by month

<table>
<thead>
<tr>
<th></th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>19</td>
<td>11</td>
<td>4</td>
<td>12</td>
<td>4</td>
<td>4</td>
<td>36</td>
<td>42</td>
<td>21</td>
<td>5</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>2013</td>
<td>20</td>
<td>11</td>
<td>4</td>
<td>7</td>
<td>6</td>
<td>4</td>
<td>32</td>
<td>39</td>
<td>19</td>
<td>6</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>

The chart below shows clearly where the peaks in initial registration applications occurred.

Figure 1 – number of new registrants during 2014 by month

Table 2 - 2014 new registrants by registration route

<table>
<thead>
<tr>
<th>Registration route</th>
<th>Total new registrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Route 1 – UK accredited course</td>
<td>159</td>
</tr>
<tr>
<td>Route 2 – Foreign qualified</td>
<td>13</td>
</tr>
<tr>
<td>Route 3 – EU General Directive</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>179</strong></td>
</tr>
</tbody>
</table>

What this tells us

The majority of initial registration applications were received at the beginning of the year (January – February) and again from July to September. This follows graduation from accredited courses from the three UK institutions offering chiropractic training, and which makes up the vast majority of registration applications.
The flow of work is largely in line with 2013, although there was a slight increase in new registrants during November and December. This can be explained by a cohort from the McTimoney College of Chiropractic (MCC) graduating in October in 2014 and therefore applying for registration earlier than the December cohort. This has led to their registration falling within the 2014 registration year rather than the following year as occurs with the December cohort. In previous years there have not been graduates from MCC in October as all students graduated from December.

In total 159 new registrants graduated from colleges with a GCC recognised qualification and therefore made up the largest proportion of new registrants during 2014. Only 13 were registered on the basis that they held a foreign chiropractic qualification and by passing a test of competence, while the remaining 7 registrants where registered on the basis that they held EU community rights and had practised within the EEA.

Routes to GCC registration

Route 1 – by accredited course (UK)
By holding a chiropractic qualification recognised for the purposes of registration by the GCC. As the GCC has only been asked to accredit courses within the UK, only graduates of relevant courses from the three UK colleges are eligible through this route, (Anglo-European College of Chiropractic, McTimoney College of Chiropractic and the University of South Wales).

Route 2 – unrecognised foreign chiropractic qualification (test of competence)
By holding a chiropractic qualification from without the UK that meets the requirements of the relevant GCC rules and also meeting the Standard of Proficiency by passing the test of competence.

Route 3 – EU General Directive (establishment)
By virtue of European Union (EU) General Directive 2005/36/EC. Applicants must possess EU community rights and meet the requirements of establishment in another European Economic Area (EEA) member state.

Route 4 – EU General Directive (temporary and occasional)
By virtue of European Union (EU) General Directive 2005/36/EC. Applicants must possess EU community rights, meet the requirements of establishment in another European Economic Area (EEA) member state and also intend to practise in the UK only on a temporary and occasional basis.
Applicants holding a UK recognised qualification (route 1)
The GCC recognises courses from three UK educational institutions. These are the only
UK courses that allow individuals to apply for registration once completed.

The breakdown below gives the numbers of 2014 graduates of accredited courses who
were granted registration by 1 March 2015.

Table 3 – new registrants registered during 2014 by institution

<table>
<thead>
<tr>
<th>Educational institution</th>
<th>Month course completed</th>
<th>Number of graduates</th>
<th>Number registered</th>
<th>% of graduates registered during 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>McTimoney College of Chiropractic (MCC)</td>
<td>December 2013</td>
<td>36</td>
<td>31</td>
<td>86.1</td>
</tr>
<tr>
<td>Anglo-European College of Chiropractic (AECC)</td>
<td>June/ July 2014</td>
<td>113</td>
<td>60</td>
<td>53.1%</td>
</tr>
<tr>
<td>University of South Wales</td>
<td>June/ July 2014</td>
<td>60</td>
<td>45</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td><strong>209</strong></td>
<td><strong>136</strong></td>
<td><strong>65.1</strong></td>
</tr>
</tbody>
</table>

What this tells us
While roughly the same percentage of MCC graduates have gone on to register as from the
December 2012 cohort, the percentage of graduates from both the AECC and the
University of South Wales are noticeably different from the 2013 figures.

When comparing the figures for 2013, we see that a higher percentage of the 2014 AECC
cohort registered, with 53.1% registering in 2014 compared to 43% in 2013. While 91.7% of
the 2013 University of South Wales cohort registered, that figure dropped for 2014 to 75%.
It's worth bearing in mind that those who have not yet applied may do so at any time in the
future as there is no time limit.

We have estimated that of those who have not yet registered, some 80% are overseas
nationals, with the remaining 20% made up of both UK and dual (including UK) nationality.
This then falls within the range of our expectations and we would expect to see a
proportion of graduates who are not yet registered applying in the future.
Applicants holding a relevant foreign chiropractic qualification (route 2)

For those who achieved a chiropractic qualification outside the UK, GCC registration is possible by applying to register and taking the additional step of passing a test of competence. The test of competence is designed to ensure that those applicants who do not have a qualification accredited by the GCC meet the same standards as those who do.

Table 4 – new foreign qualified registrants by educational institution

<table>
<thead>
<tr>
<th>Educational institution</th>
<th>Country</th>
<th>Number of registrants</th>
<th>Year of graduation (total graduates in brackets)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleveland</td>
<td>USA</td>
<td>1</td>
<td>2002</td>
</tr>
<tr>
<td>Durban</td>
<td>South Africa</td>
<td>1</td>
<td>2013</td>
</tr>
<tr>
<td>Life</td>
<td>USA</td>
<td>1</td>
<td>2012</td>
</tr>
<tr>
<td>Macquarie University</td>
<td>Australia</td>
<td>9</td>
<td>1992 (1) 2010 (2) 2012 (1) 2013 (3) 2014 (2)</td>
</tr>
<tr>
<td>Southern California</td>
<td>USA</td>
<td>1</td>
<td>2011</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>13</strong></td>
<td><strong>-</strong></td>
</tr>
</tbody>
</table>

What this tells us

The number of those applying by holding a relevant, unrecognised chiropractic qualification is significantly smaller than those graduating from accredited courses, with an overall figure of those achieving registration via route 2 at 13.

As was the case in 2013, over half of those granted registration during 2014 under the foreign qualification rules were graduates of Macquarie University, New South Wales, Australia. However, unlike 2013, where 100% of those granted registration had graduated within the previous two years, in 2014 only 55% had done so.

Those 13 registered through route 2 in 2014 graduated over a wider period of time, but from fewer colleges – seven colleges in 2013. However, given that the numbers remain small; minor fluctuations can dramatically change these figures.

Test of Competence

During 2014 the Test of Competence was administered on behalf of the GCC by the University of South Wales.

The GCC’s contract with the University of South Wales, for running the test came to an end in September 2014. During the period running up to the end of the contract the GCC reviewed the test and made arrangements for a new Test of Competence to be in place by January 2015.
Table 5 – number of tests and candidates per annum since 2008

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of tests per year</th>
<th>Number of test attempts per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>4</td>
<td>27</td>
</tr>
<tr>
<td>2009</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>2010</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>2011</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>2012</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>2013</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>2014</td>
<td>2</td>
<td>20</td>
</tr>
</tbody>
</table>

Table 6 – breakdown of number of candidates per test for 2014

<table>
<thead>
<tr>
<th>Test dates</th>
<th>Number of candidates</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 March</td>
<td>12</td>
</tr>
<tr>
<td>14 June</td>
<td>8</td>
</tr>
<tr>
<td>13 September</td>
<td>Cancelled</td>
</tr>
</tbody>
</table>

What this tells us

In line with figures for the past five years, the total number of candidates for the test has remained around 20. Three tests were scheduled for 2014, although the final test in September was subsequently cancelled as the minimum number of six candidates was not realised.

One possible reason for the lack of candidates may have been because some potential candidates held back from taking the September test in the belief the revised test of competence would be easier.

Breakdown by candidates graduating college for each test

Table 7 – 22 March 2014 test of competence

<table>
<thead>
<tr>
<th>Institution</th>
<th>Total candidates</th>
<th>Pass</th>
<th>Fail</th>
<th>Resits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durban</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Life</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Macquarie</td>
<td>8</td>
<td>7</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>South California</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>8</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 8 – 14 June 2014 test of competence

<table>
<thead>
<tr>
<th>Institution</th>
<th>Total candidates</th>
<th>Pass</th>
<th>Fail</th>
<th>Resits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Macquarie University</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>New Zealand</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>South California</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Royal Melbourne Institute of Technology</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8</strong></td>
<td><strong>6</strong></td>
<td><strong>2</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

Table 9 – total of candidates of all 2014 tests

<table>
<thead>
<tr>
<th>Institution</th>
<th>Total candidates</th>
<th>Pass</th>
<th>Fail</th>
<th>Resits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durban</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Life</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Macquarie</td>
<td>10</td>
<td>9</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>New Zealand</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>South California</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Royal Melbourne Institute of Technology</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
<td><strong>14</strong></td>
<td><strong>6</strong></td>
<td><strong>5</strong></td>
</tr>
</tbody>
</table>

What this tells us
Demand for the test was higher at the beginning of the year as was also seen the previous year. Essentially this is because the March test is the first test available to those newly graduated from Macquarie University. Two thirds of candidates for the March test were graduates from Macquarie University.

With a figure of 70% for 2014, the pass rate was slightly lower than in 2013 with 76%, but in excess of the mean pass rate of 66%.
Report on the 2014 GCC registration year

Table 10 – failed test components for 2014

<table>
<thead>
<tr>
<th>Component</th>
<th>Number of attempts</th>
<th>Number of failed attempts</th>
<th>% of failed attempts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical objective structured clinical examination (OSCE)</td>
<td>6</td>
<td>1</td>
<td>16.6%</td>
</tr>
<tr>
<td>UK healthcare system</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>X-ray OSCE</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Case management</td>
<td>6</td>
<td>6</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 11 – number of candidates who failed by number of failed components

<table>
<thead>
<tr>
<th>Number of failed components</th>
<th>Number of candidates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

What this tells us

All six candidates failing the test during 2014 were unsuccessful on the case management component. Only one candidate failed a further component, in this case the Clinical OSCE. In contrast to 2013, no candidate failed the UK healthcare system or X-ray OSCE components.

Four candidates failed the test in March, although there was a lower percentage of candidates than for the June test which had fewer candidates.

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

Establishment (route 3)

The number applying through the EU General Directive has remained at around the same level as 2013, with seven applicants. Those seven applied on the basis that they intended to practise within the UK on a permanent basis, which is referred to in the Directive as ‘establishment’.
Report on the 2014 GCC registration year

Table 12 – educational institution of those applying through the EU directive

<table>
<thead>
<tr>
<th>Educational institution</th>
<th>Country</th>
<th>Number of registrants</th>
<th>Year of graduation (total graduates in brackets)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insitut Franco-Européen de Chiropraxie (IFEC)</td>
<td>France</td>
<td>6</td>
<td>2000 (1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2013 (2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2014 (3)</td>
</tr>
<tr>
<td>National University of Health Sciences</td>
<td>USA</td>
<td>1</td>
<td>2000 (1)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

What this tells us
With one exception all registrants applying through the EU general directive route were French graduates of IFEC. Given the limited number of institutions offering chiropractic courses in Europe, it’s of no surprise that a higher number were from France and the IFEC, although in comparison to 2013 the diversity of qualifications was much more limited. We may have expected to see a number of graduates from one of the other educational institutions within the EU running chiropractic programmes, or even, as in the past more applicants with qualifications from outside the EU.

Table 13 – nationality of those applying through the EU General Directive

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Number of registrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>British</td>
<td>1</td>
</tr>
<tr>
<td>French</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
</tr>
</tbody>
</table>

What this tells us
A comparison of 2013 and 2014 figures in relation to nationality shows that while French nationals made up the largest contingent of registrants during 2013, it was not nearly as large as the 2014 contingent. It’s unclear at this stage whether this represents a pattern that will be repeated in future years.

Temporary registration (route 4)
2014 was the first time that the GCC had accepted an application under the directive for temporary registration. The registrant was a French national holding a recent qualification from IFEC. As they subsequently wished to remain in the UK, they have gained full registration under the EU General Directive on the basis of establishment and their data is included in the section above.
Future application numbers

Before looking at any trends it should be mentioned that while we can consider previous statistics to look for future trends, the many variables mean they should be considered as ‘best guesses’ only.

The largest variable is the number of new graduates who may apply for registration. This is particularly important and difficult when forecasting using percentages since a small number of graduates either applying or not applying for registration will have a disproportionate effect. This can be seen by comparing the 2013 and 2014 figures for new UK graduates applying for registration, which shows that 123 out of the 210 graduates from 2013 registered, equating to 58.6%, while in 2014 just 13 more graduates registered bringing the total to 136, increasing the percentage up to 65%.

Also when forecasting numbers of new registrants for future years, the rate of attrition of students comes into play and the further into the future the stones are cast the bigger the extrapolation has for error.

Table 14 – potential graduates from UK educational institutions for the following five years

<table>
<thead>
<tr>
<th>Educational institution</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglo-European College of Chiropractic</td>
<td>109</td>
<td>75</td>
<td>120</td>
<td>110</td>
<td>105</td>
</tr>
<tr>
<td>University of South Wales</td>
<td>78</td>
<td>98</td>
<td>68</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>McTimoney College of Chiropractic</td>
<td>41</td>
<td>43</td>
<td>34</td>
<td>29</td>
<td>28</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>228</td>
<td>216</td>
<td>222</td>
<td>219</td>
<td>213</td>
</tr>
</tbody>
</table>

What this tells us

While the overall number of potential graduates remains between 213 and 228 for the next five years, there is some considerable difference in the number of graduates from each institution in certain years, as shown in the shaded areas of table 14 above. While not as important as the total of potential graduates, it shows that there is capacity for dips in graduates in some years that reduce the overall number wishing to apply for registration.

Table 15 – projected registration figures for the following five years

<table>
<thead>
<tr>
<th>Educational institution</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK graduates*</td>
<td>141</td>
<td>134</td>
<td>138</td>
<td>136</td>
<td>132</td>
</tr>
<tr>
<td>Foreign Qualified</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>EU Directive</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>161</td>
<td>154</td>
<td>158</td>
<td>156</td>
<td>152</td>
</tr>
</tbody>
</table>

* these figures have been calculated assuming a registration rate of 62% for UK graduates, which is the average of the past two years.
Report on the 2014 GCC registration year

Figure 2 - total of potential registrants for the following five years

What this tells us
Over the next five years a period of relative stability in the number of new registrants is the most likely outcome. We are not aware of any factors currently that may dissuade large numbers of new graduates from registering, nor that would prevent students from completing their course.

Retentions
Summary
By the end of the 2014 retention period on 14 December 2014, 2,965 registrants had retained on the Register for 2015.

Factors affecting annual retention figures:
- as noted below, there are a number of reasons individuals will register as non-practising
- there are a number of people who will leave the Register on an annual basis; and
- there are a number of individuals who will register for the first time after 10 November each year in order to pay the initial registration fee rather than the initial registration fee and the retention fee.

These factors make it difficult to determine actual retention income for any period as we reply on past trends in forecasting.

Non-practising rate of registration
Schedule 2 of the GCC (Registration) Rules 1999 allows a registrant not intending to practise as a chiropractor within the UK for the duration of the registration year to pay a reduced fee of £100.

At the end of December 2014 there were 277 registrants who had paid the £100 non-practising rate as they did not intend practising in the UK during 2015, representing 10% of the profession in total.
Report on the 2014 GCC registration year

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

<table>
<thead>
<tr>
<th></th>
<th>Number of registrants</th>
<th>% age of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>1</td>
<td>0.36</td>
</tr>
<tr>
<td>Financial</td>
<td>2</td>
<td>0.72</td>
</tr>
<tr>
<td>Overseas licensing</td>
<td>2</td>
<td>0.72</td>
</tr>
<tr>
<td>Teaching</td>
<td>2</td>
<td>0.72</td>
</tr>
<tr>
<td>Travelling</td>
<td>2</td>
<td>0.72</td>
</tr>
<tr>
<td>Education</td>
<td>7</td>
<td>2.53</td>
</tr>
<tr>
<td>Career change</td>
<td>8</td>
<td>2.89</td>
</tr>
<tr>
<td>Sabbatical</td>
<td>11</td>
<td>3.97</td>
</tr>
<tr>
<td>Unknown</td>
<td>11</td>
<td>3.97</td>
</tr>
<tr>
<td>Not working as a chiropractor</td>
<td>25</td>
<td>9.03</td>
</tr>
<tr>
<td>Maternity/ Child care</td>
<td>32</td>
<td>11.55</td>
</tr>
<tr>
<td>Overseas</td>
<td>174</td>
<td>62.82</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>277</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

What this tells us
Most of those paying the non-practising rate did so as they were practiseing, but outside of the GCC’s jurisdiction, making up over 60% of the total. The next largest group were those taking a break from their careers for maternity and child care reasons.

Those who had changed careers and also those no longer working as chiropractors totalled 33 registrants. Although we do not have data on what all of these individuals are doing, we are aware that some have gone through additional training to work in other healthcare fields. This does raise questions as to why those not intending to work in the chiropractic profession again either wish to remain registered or are able to do so.

Removals from the Register
Continued registration is dependant upon registrants complying with all requirements of registration. Failure to meet those requirements can lead to removal from the Register. Removal from the Register can be for any of the following reasons:

Failure to remain fit to practise (struck-off)
Registrants who do not meet the standards as set out within the GCC’s Code of Practice/Standard of Proficiency, or who do not comply with GCC legislation, may be removed from the Register.

Failure to retain on the Register (lapse)
All registrants must provide a full application for retention on the Register before the statutory deadline of 30 November in any given registration year. Should the application not arrive by deadline a final warning notice is issued, allowing the registrant a further 14 days to ensure their application for retention has arrived.
Report on the 2014 GCC registration year

If at the end of those 14 days the application has not arrived then removal from the Register is automatic.

Failure to complete annual CPD requirements (CPD non compliance)
Each year all registered chiropractors must fill in and return a CPD record summary to show the learning they have accomplished to comply with the GCC’s CPD scheme. Those registrants who do not provide a summary, or who fail to meet the requirements of the scheme, may be removed from the Register.

Voluntary removal
In addition to these, the GCC rules allow a registrant to remove his or her name from the Register at any time by filling in the relevant application form and a statutory declaration.

Table 17 - method of removal from the Register during 2014 by month

<table>
<thead>
<tr>
<th></th>
<th>Struck off</th>
<th>Lapse</th>
<th>Voluntary</th>
<th>Deceased</th>
<th>CPD non compliance</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>February</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>March</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>April</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>May</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>June</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>July</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>August</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>September</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>October</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>41</td>
<td>45</td>
</tr>
<tr>
<td>November</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>December</td>
<td>0</td>
<td>36</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>45</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>39</td>
<td>21</td>
<td>2</td>
<td>42</td>
<td>107</td>
</tr>
</tbody>
</table>

What this tells us
Essentially table 17 tells us exactly what we would expect, that the majority of removals from the Register fall in October at the end of the CPD period and after the retention period in December. The remaining 17 removals occurred throughout the year and were largely made up of voluntary removals, those who had died and those who were struck-off the Register.
Reasons for no longer remaining on the Register

These figures have been collated from voluntary removal application forms and email correspondence with registrants. Where a registrant’s last known registered address was overseas, it has been accepted as the reason they did not wish to remain on the Register.

Table 18 – reasons for no longer remaining on the Register

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of registrants</th>
<th>As a percentage</th>
<th>Since restored to the Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial reasons</td>
<td>1</td>
<td>0.93</td>
<td>0</td>
</tr>
<tr>
<td>Maternity</td>
<td>1</td>
<td>0.93</td>
<td>1</td>
</tr>
<tr>
<td>Sabbatical</td>
<td>1</td>
<td>0.93</td>
<td>0</td>
</tr>
<tr>
<td>Unemployed</td>
<td>1</td>
<td>0.93</td>
<td>0</td>
</tr>
<tr>
<td>Travelling</td>
<td>1</td>
<td>0.93</td>
<td>1</td>
</tr>
<tr>
<td>Dissatisfaction with the profession</td>
<td>2</td>
<td>1.87</td>
<td>0</td>
</tr>
<tr>
<td>Returned to education</td>
<td>2</td>
<td>1.87</td>
<td>0</td>
</tr>
<tr>
<td>Deceased</td>
<td>2</td>
<td>1.87</td>
<td>0</td>
</tr>
<tr>
<td>Career change</td>
<td>3</td>
<td>2.80</td>
<td>0</td>
</tr>
<tr>
<td>Health</td>
<td>3</td>
<td>2.80</td>
<td>0</td>
</tr>
<tr>
<td>Struck Off</td>
<td>3</td>
<td>2.80</td>
<td>0</td>
</tr>
<tr>
<td>Missed deadline to retain in the Register</td>
<td>3</td>
<td>2.80</td>
<td>3</td>
</tr>
<tr>
<td>Retired</td>
<td>15</td>
<td>14.02</td>
<td>0</td>
</tr>
<tr>
<td>Unknown</td>
<td>30</td>
<td>28.04</td>
<td>0</td>
</tr>
<tr>
<td>Working overseas</td>
<td>39</td>
<td>36.45</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>107</strong></td>
<td><strong>100.00</strong></td>
<td><strong>8</strong></td>
</tr>
</tbody>
</table>

What this tells us

There were a range of reasons for registrants no longer remaining on the Register. Over a third of those coming off the Register did so as they were no longer working in the UK. As we do not have data on 28% of leavers, this figure will in fact be higher.

Table 19 - whether those coming off the Register were practising or non-practising

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of registrants</th>
<th>As a %age of removers</th>
<th>As a %age of the Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practising</td>
<td>68</td>
<td>64%</td>
<td>90%</td>
</tr>
<tr>
<td>Non-practising</td>
<td>39</td>
<td>36%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>107</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
What this tells us
A larger proportion of those coming off the Register during 2014 were non-practising than practicing. We believe this is because registrants are cautious about coming off the Register initially and prefer to remain as non-practising in case their circumstances change. There is still a perception among a small number of registrants that restoring to the Register is a complicated process involving passing the test of competence, although this has never been the case.

A comparison of the reasons given for paying the non-practising rate or leaving the Register

Fig 3 - the main reasons given by those leaving the Register and those paying the non-practising rate

What this tells us
Figure 3 shows that for both those registrants paying the non-practising rate and those leaving the Register, their main reason for doing so is an intention to practise overseas.

There is some equity between the remaining categories, except for those on maternity leave/child care, where substantially more pay the non-practising rate (32 registrants) than leave the Register (one registrant) entirely.
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Diversity of the Register
The sex and date of birth of all applicants is collected on the registration application form.

Split by sex of new registrants
The following data gives details of the split by sex for all those registered between 1 January and 31 December 2014.

Figure 4 - new registrants by sex

What this tells us
The percentage of female new registrants in 2014 was 52.5%, which was 9% higher than 2013. The split by sex within the profession has largely been 50:50 for some time, although in recent years there have been more male new registrants than female.

The figures for 2014 show that the number of new male registrants remained around the mid 80 mark, while there were an additional 26 new female registrants in 2014, which given the number of new registrants was only 179, is a significant number.

Age split of new registrants
The following data gives details of the age split for all those registered between 1 January and 31 December in 2013 and 2014.
Report on the 2014 GCC registration year

What this tells us

New registrants are largely made up of those under 30, which is as we would expect given that the majority of those are new graduates.

Comparing 2014 figures with 2013 simply shows that this trend continues with a minor increase in those under 30 and in the 45 – 49 brackets at the expense of those between 30 and 44.

Split by sex of the Register as a whole

Figures 6 – split by sex of registrants per year since 2006

What this tells us

There is a trend of almost a 50:50 split. The difference is now so small that there are fewer than 10 individuals between the two totals with 1,513 male and 1,508 female.

Split by age of the Register as a whole

Figure 7 – age split of the Register since 2006

What this tells us

There is a trend of mostly 30-44 to 45-59. The difference is now so small that the majority of those are under 30.
What this tells us
The overall age profile of registrants was the same as for 2013. The general trend of a reduction in the under 45 bracket and an increase in those over 46 seems to be levelling off, which may be as a result of stability in the number of new graduates and those leaving the Register.

Communications
During 2014 the registrations team engaged with stakeholders in a number of areas.

New Continuing Professional Development (CPD) guidance
In early April 2014 the GCC published revised guidance on its CPD scheme, resulting in the merging of two previous documents:
1. Mandatory CPD guidance published in 2004; and
2. CPD guidance published.

The purpose of the revised document was to aid clarity, giving examples of the learning that is acceptable as CPD and the learning that does not fall within the current scheme. However, given the terms used within the CPD rules themselves, it has not been possible to entirely avoid ambiguity.

Revised dates for submission of annual CPD record summary
In previous years registrants submitted their annual CPD record summary along with their annual retention application, the deadline for which is the end of November each year. This has meant that the registrations section has not had an opportunity to check the content of all CPD returns in the past. An emphasis has therefore been placed on confirming that the full 30 hours have been completed and that all relevant sections of the summary have been filled in.

In 2014 for the first time we brought the deadline for return of completed CPD record summaries forward to 30 September. The purpose of this change was to allow the office
enough time to check every summary and to ensure compliance with the CPD rules and guidance. Where issues are identified there is then enough time for these to be rectified.

The vast majority of issues we identified were down to misinterpretation of the guidance by registrants or summaries that did not give adequate information of either the identified learning need or the learning activities themselves. In the majority of cases issues were resolved quickly when registrants provided further detail.

A report based on issues identified in the 2014 CPD returns has been compiled and fed into the ongoing CPD review. It can also be found on the GCC website here.

**Monthly registration movement reports**
Since January 2014 the GCC has produced a monthly report showing movements on the Register of Chiropractors. This includes new registrants, those coming off the Register and when sanctions have been imposed upon registrants affecting their ability to practise.

The report is published online and also circulated to professional associations and those private healthcare providers holding lists of chiropractors available to the public, this is to help ensure they are referring to up-to-date information.

**Registration of chiropractors in Isle of Man and Gibraltar**
During 2014 the GCC was approached by the respective governments of both the Isle of Man and Gibraltar, bringing in separate legalisation requiring all of those calling themselves chiropractors within their jurisdictions to hold registration with the GCC.

A memorandum of understanding was signed with the Isle of Man Government during 2014 and, a further memorandum was agreed with the authorities in Gibraltar and signed on 14 January 2015.
Report on the 2014 GCC registration year

For further information on registrations or CPD, please contact:
Registrations team
General Chiropractic Council
44 Wicklow Street
London
WC1X 9HL
020 7713 5155
www.gcc-uk.org
enquiries@gcc-uk.org
To: The Council, General Chiropractic Council

From: Paul Ghuman, Director of Resources and Regulation

Subject: Budget 2015 review

Date: 31 March 2015

Background

In 2014, we predicted a deficit budget for that financial year of £283K. In fact, the actual figure was considerably less, being £116k. This was as a result of efficiency savings introduced in prior years.

We are forecasting a small surplus of £10k in 2015 followed by steadily rising surpluses of £102k in 2016 and £174k in 2017.

At the last meeting of Council members wished to review the income figures, especially in relation to initial registrations. The numbers in relation to initial registration trends are shown in the annual registration report which has been considered earlier in this meeting.

The executive has revised the budget with internal transfer of funds, which do not affect the agreed budget surplus for 2015. This is now attached as Annex A to this paper.

The revised financial forecast for 2015-2017 is at Annex B. For reference, the budget paper presented to Council in December 2014 is attached as Annex C.

Review of 2015 budget

1. The proposed budget showed an income of £2,494k against the 2014 actual figure of £2,365k. This is an increase of 5%.

2. The budget shows an expenditure spend of £2,484k against the 2014 actual of £2,440k, an increase of 2%.

3. The projected surplus is maintained at just over £10k.

4. The financial forecast for the following years shows a surplus of £102k in 2016 and £174k in 2017.

Council needs to be aware of the following:

- Accommodation costs have been reduced by £25k following renegotiation;

- The Audit Committee has decided that in seeking adequate assurance measures for FtP, the frequency of audit of IC cases will increase from once a year to quarterly. This is to ensure that there is consistent improvement in the investigation of cases. Furthermore, these audits will also comment on the reasonableness and adequacy of the IC decisions. We will also seek to introduce an audit of our PCC cases during the year. These audits will have an additional net cost of additional £11k; and

- Further transfers of funds are relatively minor, but the overall changes do not have an impact on the surplus position for the year.
Key impact to budget

It should also be noted that the forecast retention income is below that actually received to date by £18.5k. This is a variance of less than 1%. There are a number of variables when forecasting this figure. These have been identified in the annual registration report considered earlier at this meeting. At present other income streams are offsetting this difference.

Action Required

Council is asked to note the transfer of funds within the original budget.

Paul Ghuman
Email: p.ghuman@gcc-uk.org
Telephone: 020 7713 5155
Annex A

Budget 2015 Summary

<table>
<thead>
<tr>
<th></th>
<th>2014 budget</th>
<th>2014 actual</th>
<th>2015 budget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
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<td></td>
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<tr>
<td>Initial Registration</td>
<td>139,500</td>
<td>114,000</td>
<td>137,250</td>
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<tr>
<td>Retention - Practising</td>
<td>2,074,400</td>
<td>2,065,200</td>
<td>2,143,200</td>
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<tr>
<td>Retention - Non Practising</td>
<td>24,900</td>
<td>30,400</td>
<td>30,300</td>
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<tr>
<td>Non practising to practising</td>
<td>8,000</td>
<td>24,000</td>
<td>8,000</td>
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<tr>
<td>Restoration</td>
<td>7,500</td>
<td>11,450</td>
<td>7,500</td>
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<td>Investment Income</td>
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<td></td>
</tr>
<tr>
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<td>922,786</td>
<td>999,641</td>
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<td>75,019</td>
<td>80,000</td>
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<td>2,484,236</td>
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<td><strong>Surplus / (Deficit) sub total (A-B)</strong></td>
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<td>(116,095)</td>
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### Financial Forecast Summary 2015-2017

<table>
<thead>
<tr>
<th>Income</th>
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<th>2016</th>
<th>2017</th>
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<td>Investment Income</td>
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<table>
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<th>2017</th>
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<tr>
<td>Education</td>
<td>25,130</td>
<td>25,779</td>
<td>22,947</td>
</tr>
<tr>
<td>Fitness to Practice</td>
<td>617,000</td>
<td>537,180</td>
<td>517,365</td>
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<tr>
<td>Contingency</td>
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<td>0</td>
<td>0</td>
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<tr>
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<td>2,445,523</td>
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<table>
<thead>
<tr>
<th>Surplus / (Deficit) sub total (A-B)</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10,014</td>
<td>102,397</td>
<td>174,027</td>
</tr>
</tbody>
</table>
To: The Council, General Chiropractic Council  
From: Paul Ghuman, Director of Resources and Regulation  
Subject: Draft Budget 2015 and Capital Plan  
Date: 1 December 2014

Summary

In 2014, the budget showed a deficit of £283k, due to the bulge in PCC cases. Council had decided that that the GCC would aim to hold extra hearings to eradicate the backlog created by the discovery, in 2012, of six times the usual annual number of complaints which were previously accounted for. The forecast for 2015 shows that the GCC has recovered faster than anticipated; instead of a small deficit in 2015 the draft budget shows a surplus. This surplus will increase in 2016 and 2017.

As such, there is no required drawdown on our investment portfolio.

Introduction

1. The proposed Budget for 2015 is to support the delivery of the Business Plan 2015.
2. The ongoing resourcing issues facing the organisation relate to reducing the number of cases with the Professional Conduct Committee (PCC) waiting for determination.
3. This bulge in PCC cases followed the decisions taken by the Investigating Committee on almost 240 cases since April 2012. This led to a large number of cases being referred to the PCC. A large number of cases will have been determined during 2013 and 2014, which will allow the GCC to meet its KPI for determining 90% of cases referred within 9 months. The proposed budget seeks to maintain a relatively high number of hearing days in 2015.
4. The costs in relation to FtP will reduce somewhat in 2015, as it will be the first full year of processing, investigating and presenting cases with an in-house legal team.
5. Attached at Annex A is the budget for 2015 with best and worst-case scenarios.
6. The proposed budget shows an income of £2,494k (2014 budget £2,414k) and expenditure of £2,484k (2014 budget £2,697k), giving a budgeted surplus of £10k.
7. The main budget increases are in relation to staffing, IT and Council costs. The total increase on these budget lines is £107k. Other budget lines are showing a decrease on the 2014 budget of £320k. This leads to a total expenditure decrease of £213k from the 2014 budget. A reduction of 7.8% from the 2014 budget.
8. Income lines show an increase of income of £80k on the 2014 budget. This is a 3.3% increase on the 2014 budget position.
9. Taking income and expenditure together, the total budget movement from 2014 to 2015 is £293k leading to a forecast surplus of £10k.
10. The financial forecast for the following years shows a surplus of £94k in 2016 and £167k in 2017.
Key provisions

11. The budget for 2015 assumes no increase in the Annual Retention Fee paid by registrants during the period.

12. There is an allowance for a levy to the PSA of £6k.

13. There is no allowance for continuing fitness to practise (formerly known as revalidation) costs as these costs are met from the DH grant fund.

14. There is a current provision for an increase of 3% staff pay award. The actual salary increase will be determined by the Remuneration Committee on 24 November and clearly has not been reflected in this paper.

Budget 2015 Summary

<table>
<thead>
<tr>
<th></th>
<th>2014 budget</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Registration</td>
<td>139,500</td>
<td>137,250</td>
</tr>
<tr>
<td>Retention - Practising</td>
<td>2,074,400</td>
<td>2,143,200</td>
</tr>
<tr>
<td>Retention - Non Practising</td>
<td>24,900</td>
<td>30,300</td>
</tr>
<tr>
<td>Non practising to practising</td>
<td>8,000</td>
<td>8,000</td>
</tr>
<tr>
<td>Restoration</td>
<td>7,500</td>
<td>7,500</td>
</tr>
<tr>
<td>Investment Income</td>
<td>160,000</td>
<td>168,000</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>2,414,300</td>
<td>2,494,250</td>
</tr>
</tbody>
</table>

|                      |             |         |
| **Expenditure**      |             |         |
| Staff Costs          | 914,283     | 997,114 |
| IT costs             | 69,000      | 80,000  |
| Office Costs         | 206,020     | 183,500 |
| Accommodation costs  | 274,200     | 248,200 |
| Finance costs        | 19,000      | 21,465  |
| Professional fees    | 165,500     | 135,000 |
| Council costs        | 153,300     | 166,800 |
| Communication        | 18,000      | 18,000  |
| Registrations        | 6,000       | 7,500   |
| Education            | 34,500      | 25,130  |
| Regulation           | 837,500     | 602,000 |
| Contingency          | 0           | 0       |
| **Expenditure**      | 2,697,303   | 2,484,209 |

| **Surplus / (Deficit)** | (283,003) | 10,041 |
### Financial Forecast Summary 2015-2017

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Initial Registration</td>
<td>137,250</td>
<td>137,250</td>
<td>120,000</td>
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<tr>
<td>Retention - Practising</td>
<td>2,143,200</td>
<td>2,209,600</td>
<td>2,276,000</td>
</tr>
<tr>
<td>Retention - Non Practising</td>
<td>30,300</td>
<td>30,300</td>
<td>30,300</td>
</tr>
<tr>
<td>Non practising to practising</td>
<td>8,000</td>
<td>8,000</td>
<td>8,000</td>
</tr>
<tr>
<td>Restoration</td>
<td>7,500</td>
<td>7,500</td>
<td>7,500</td>
</tr>
<tr>
<td>Investment Income</td>
<td>168,000</td>
<td>176,000</td>
<td>184,000</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>2,494,250</td>
<td>2,568,650</td>
<td>2,625,800</td>
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<td><strong>Expenditure</strong></td>
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<td>Finance costs</td>
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<td>Professional fees</td>
<td>135,000</td>
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<td>Council costs</td>
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<td>Registrations</td>
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<td>Education</td>
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<td>Regulation</td>
<td>602,000</td>
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<td>94,210</td>
<td>166,741</td>
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</table>
### Budget details

#### Income

15. The draft income budget is:

<table>
<thead>
<tr>
<th></th>
<th>2014 budget</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Registration</td>
<td>139,500</td>
<td>137,250</td>
</tr>
<tr>
<td>Retention - Practising</td>
<td>2,074,400</td>
<td>2,143,200</td>
</tr>
<tr>
<td>Retention - Non Practising</td>
<td>24,900</td>
<td>30,300</td>
</tr>
<tr>
<td>Non practising to practising</td>
<td>8,000</td>
<td>8,000</td>
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<tr>
<td>Restoration</td>
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<td>7,500</td>
</tr>
<tr>
<td>Investment Income</td>
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<td>168,000</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>2,414,300</strong></td>
<td><strong>2,494,250</strong></td>
</tr>
</tbody>
</table>

Overall income is as follows:

16. The overall income position is that the 2015 budget of £2,494k is an increase of £80k on the 2014 budget. The main reasons are an increase of £74k in the retention fees number and an increase on investment income based on an increase of 2% in the portfolio valuation.

#### Staffing

17. The staff expenditure budget is:

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<td><strong>Staff Cost Total</strong></td>
<td><strong>914,283</strong></td>
<td><strong>997,114</strong></td>
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</table>

18. Staff salaries increase as a result of full-year costs for three new posts recruited during 2014. The staff costs budget also includes a 3% increase in the pay award. These changes will lead to an increase in salaries of £67k.

19. Temporary staff costs have been higher than expected over the past few years. The requirement for temporary staff to support the effective functioning of the office in peak periods has led to an increase in the budget to £18k.

20. The staff Recruitment budget includes provision for two vacancy advertisements, with the rest of the appointment cost being staff time.

21. Staff Development is budgeted at £750 per employee.
22. Other staff costs – this includes the CER budget for travel etc. and has been under-utilised in 2014. It is predicted to increase in 2015 as more meetings with stakeholders are anticipated.

**IT costs**

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<td><strong>80,000</strong></td>
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</table>

23. The budget for 2015 is £84k.

24. Computer costs are maintained at £48k in 2015.

25. The website links will need to be improved for social media use and also work will take place on improving the home page.

26. There will be a requirement for planned development of the CRM database in 2015 in order to enhance CPD capabilities.

**Office costs**

27. In total, office costs reduce by £23k with the main changes being in relation to a reduction in rates, along with an increase in insurance costs.

**Accommodation**

<table>
<thead>
<tr>
<th></th>
<th>2014 budget</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Rental</td>
<td>101,000</td>
<td>101,000</td>
</tr>
<tr>
<td>Service Cost -TBC</td>
<td>16,000</td>
<td>17,600</td>
</tr>
<tr>
<td>Hearing Venue Costs</td>
<td>157,200</td>
<td>129,600</td>
</tr>
<tr>
<td><strong>Accommodation Costs</strong></td>
<td><strong>274,200</strong></td>
<td><strong>248,200</strong></td>
</tr>
</tbody>
</table>

28. Accommodation costs include rent for the full year at £101K per annum.

29. A provisional amount for service cost in line with that of 2014.

30. Hearing venue costs have decreased due to a small reduction in hearing days in 2015. Further work is being done to reduce the daily cost. No allowance for this has been included.

**Finance costs**

31. Overall finance costs have increased from £19k to £21k. This is as a result of banking charges being applied. These were not applied when the GCC had a mortgage on the property.
Professional fees

32. The budget for professional fees has decreased to £135k from a budget of £165k in 2014.

<table>
<thead>
<tr>
<th>Services</th>
<th>2014 budget</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSA levy</td>
<td>-</td>
<td>6,000</td>
</tr>
<tr>
<td>Legal Fees</td>
<td>60,000</td>
<td>54,000</td>
</tr>
<tr>
<td>Project and Consultancy fees</td>
<td>96,000</td>
<td>70,000</td>
</tr>
<tr>
<td>Human Resources</td>
<td>9,500</td>
<td>5,000</td>
</tr>
<tr>
<td><strong>Professional Fees Total</strong></td>
<td><strong>165,500</strong></td>
<td><strong>135,000</strong></td>
</tr>
</tbody>
</table>

33. A levy to the PSA has been included as this is likely to be in place for 2015/16.

34. Legal fees have been budgeted again at £54k for 2015. There is no set requirement for this, but recent history has shown that this level of expenditure is required.

35. Project and consultancy fees include the key audits and external costs in delivering the activities in the business plan. The total for 2015 is £70k. This is made up of:

<table>
<thead>
<tr>
<th>Professional consultancy fees</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pennington's audit of IC and PCC decisions</td>
<td>7,500</td>
</tr>
<tr>
<td>Audit of case files- BB</td>
<td>7,500</td>
</tr>
<tr>
<td>Feedback system from FTP case</td>
<td>2,000</td>
</tr>
<tr>
<td>Welsh Language scheme translation</td>
<td>3,000</td>
</tr>
<tr>
<td>SOPCOP printing and distribution</td>
<td>10,000</td>
</tr>
<tr>
<td>Degree Recognition Criteria</td>
<td>30,000</td>
</tr>
<tr>
<td>Indicative Sanctions Guidance</td>
<td>5,000</td>
</tr>
<tr>
<td>Review of HR policies</td>
<td>5,000</td>
</tr>
<tr>
<td>Contingency</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>70,000</td>
</tr>
</tbody>
</table>

36. Human resources budget is reduced to £5k in 2015 as compared to £9.5k in 2014.

Council costs

<table>
<thead>
<tr>
<th>Council Costs</th>
<th>2014 budget</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Council Expenses</td>
<td>39,500</td>
<td>23,000</td>
</tr>
<tr>
<td>Council Allowances</td>
<td>108,800</td>
<td>108,800</td>
</tr>
<tr>
<td>Council Development</td>
<td>5,000</td>
<td>5,000</td>
</tr>
<tr>
<td>Council Vacancies Appt Costs</td>
<td>0</td>
<td>30,000</td>
</tr>
<tr>
<td><strong>Council Cost Total</strong></td>
<td><strong>153,300</strong></td>
<td><strong>166,800</strong></td>
</tr>
</tbody>
</table>

37. In total, Council costs increase from £153k in 2014 to £166k in 2015. The 2014 figure does not included unbudgeted costs of £30k for Council appointments. There are further appointment costs in 2015 and some members come to the end of their term in early 2016 and therefore the appointment process will be carried out in 2015.

38. Council expenses are reduced from £40k in 2014 to £23k in 2015 due to a reduction in the number of Council meeting days.
39. Council allowances are now constant as all Council members are on salaries.

Communication costs

40. These costs remain the same as in 2014.

Registration

41. The registration budget is increased from £6k in 2014 to £7k in 2015.

Education

<table>
<thead>
<tr>
<th>Education</th>
<th>2014 budget</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education Committee</td>
<td>21,000</td>
<td>21,630</td>
</tr>
<tr>
<td>Recognition</td>
<td>3,500</td>
<td>3,500</td>
</tr>
<tr>
<td>Standard of Proficiency and Code of Practise</td>
<td>10,000</td>
<td>0</td>
</tr>
<tr>
<td><strong>Education Cost Total</strong></td>
<td><strong>34,500</strong></td>
<td><strong>25,130</strong></td>
</tr>
</tbody>
</table>

42. Education costs reduce from £34k in 2014 to £25k in 2015. This is simply due to the fact that the printing budget for the COP& SOP, which did not happen in 2014, has been allocated to the professional fees budget in 2015.

Fitness to Practice

<table>
<thead>
<tr>
<th>FtP</th>
<th>2014 budget</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>FtP Legal advice</td>
<td>10,000</td>
<td></td>
</tr>
<tr>
<td>Investigating Committee</td>
<td>87,500</td>
<td>70,000</td>
</tr>
<tr>
<td>Section 32</td>
<td>5,000</td>
<td>6,000</td>
</tr>
<tr>
<td>Health &amp; Professional Conduct Committee</td>
<td>705,000</td>
<td>495,000</td>
</tr>
<tr>
<td>Appeals &amp; Judicial Review</td>
<td>21,500</td>
<td>22,500</td>
</tr>
<tr>
<td>Data Protection Act and Freedom of Information</td>
<td>8,500</td>
<td>8,500</td>
</tr>
<tr>
<td><strong>FtP Cost Total</strong></td>
<td><strong>837,500</strong></td>
<td><strong>602,000</strong></td>
</tr>
</tbody>
</table>

43. The budget assumes that the Investigating Committee (IC) will sit on 12 days in the year with eight cases on average considered at each IC meeting. There will be four members at each meeting. The quorum is three members.

44. It is assumed that the workload will remain the same in 2015 as in 2014 with an average of 80 cases per annum. The increase in complaints referred to the IC is somewhat offset by a reduced percentage being referred following a ruling in the Spencer judgement.

45. The budget now also includes the IC interim suspension hearings.

Professional Conduct Committee

46. We have assumed 120 hearing days from January to December 2015. This figure is slightly lower than the number of hearing days in 2014 (131 days).
47. The reduction in costs is primarily in relation to the fact that in 2015 all the legal work will be completed in-house by the FtP team.

48. There will always be a number of cases awaiting a first hearing because of the time it takes after referral by the IC for the GCC’s Regulatory team to investigate further based on the allegation referred, assemble evidence and give adequate notice to the defence team to prepare their case. The target is nine months between referral and first hearing. We have not been able to meet that target for some time, but the expectation is that it will be met in 2015.

49. There are, however, a large number of variables which are uncontrollable. These include the relative complexity of cases in the pipeline and the level of complaints received.

**Other FtP costs**
50. FtP legal advice is now subsumed in legal advice under professional fees. This is general advice rather than case-specific advice.

**Capital Plan**

51. The Council agreed the capital plan for 2014 and to date only a small proportion of assets agreed have been purchased, the remainder will be purchased by the end of the year or in 2015. The only additional capital assets that are being considered for the 2015 period are:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer Equipment - laptops and PC’s</td>
<td>£11,000</td>
</tr>
<tr>
<td>Other Assets and Software licenses</td>
<td>£2,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£13,000</strong></td>
</tr>
</tbody>
</table>

**Public protection implications**
52. The high level of hearing days seeks to ensure that cases are dealt with in a timely manner and on achieving the GCC’s statutory duties, all of which have the aim of public protection.

**Policy and Communications implications**
53. Policy projects planned are described in the Business Plan 2015.

**Legal implications**
54. None arising from this paper.

**Resource implications**
55. These are highlighted in the paper.

**Recommendations**
56. The Council is asked to approve the proposed 2015 Budget and the Capital plan 2015.
To: Members of Council
From: Chair of the Remuneration Committee
Subject: Remuneration Committee proposal
Date: 31 March 2015

1. Purpose

To seek:

a. agreement to a change in the terms of reference of the Remuneration Committee regarding the number of members to be present for meetings to be quorate, and
b. views on the proposed review of the payments made to members of the statutory committees and Council members.

2. Background

Quorate rules

Under the existing terms of reference all members of the Remuneration Committee have to be present for a meeting to be quorate. Following the appointment of the independent member last year there are now 4 members of the Committee – 3 Council members and the independent.

Considerable difficulty was experienced in arranging the most recent meeting of the Committee so that all members could be present. To some extent that reflected a particular set of circumstances but it did serve to illustrate the problems that can arise when all members are required to attend. We have tried to mitigate this as much as we can by arranging the next meeting well in advance. However, the possibility cannot be excluded that for unseen reasons that date may prove to be inconvenient for one or more members. In which case, we will again find ourselves in difficulty in arranging a meeting in good time. We are required to provide a report to the December meeting of Council.

The Committee are seeking greater flexibility in arranging meetings by requiring 2 of the 3 Council members to be present plus the independent member.

Reviews of Non-executive remuneration

a. Members of Statutory Committees

The payment of £300 a day made to members of the IC, PCC, HC and Education Committee has remained unchanged since January 2009. Although there is no evidence to suggest that there is any particular difficulty in finding suitable individuals to sit on these Committees it is right that we should from time to time review the payments. This was last done in 2012 when Council confirmed the present rate.

It is not proposed to undertake an in depth study but to carry out a comparison with other health care regulators to establish whether the payments made by the GCC are broadly in line with those made by others. It will also take into account any other factors, e.g. recruitment and retention that might suggest that the present rate is no longer appropriate.
Council members

The present arrangement of paying Council members (other than the Chair) £6650 per annum came into effect in February 2013. Previously, members had been paid £300 per day.

Since the introduction of the annual rate there have been a number of changes to the demands placed on Council members following the independent review of the Governance arrangements. However, it is, again, not proposed to undertake an in-depth study at this time. It seems more appropriate to defer this until changes made by the Government's proposed legislation to modernise health regulation, including a smaller council, are enacted. For the same reason it would seem sensible to defer a substantive review of the Chairs remuneration.

By the time of our report to the December Council meeting the current remuneration arrangement would have been in place of almost 3 years. It seems right that these arrangements should be reviewed from time to time. It is proposed to do so by carrying out a comparative exercise of the amounts paid by other health regulators. This would be a preliminary exercise to establish whether the GCC arrangements are more or less in line with the payments made by others in this field. The contribution of the independent member of the Committee will be of particular value in formulating the Committee’s view.

If it emerges that the GCC payments are seriously out of line with those of others fuller proposals for how the matter might be addressed will be brought before Council in 2016.

3. Action

a. Council are invited to amend the Committee’s terms of reference as follows

Composition
The Committee, including its Chair, shall be appointed on the recommendation of the Chair of Council. The Committee to have 4 members, comprising at least 1 registrant and 1 lay member of the Council and 1 independent member. Meetings would be quorate if 2 Council members and the independent member were present.

b. Council are invited to note the reviews of non-executive remuneration

4. Financial implications

Any change to the remuneration of statutory committee members will have financial implications. It is not possible to say, at this stage, what the effect might be. Council will be consulted on the cost implications before any new arrangements are introduced.

5. Legal Implications

None.

6. Risk Implications

There is a potential risk to the ability of the Council to satisfactorily carry out its functions, such as the protection of the public, if it cannot recruit and retain Committee members of the right calibre.

7. Equality Implications

None

Roger Creedon
Chair of the Remuneration Committee
<table>
<thead>
<tr>
<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>4 4 16</td>
<td>Council considered the matter at its meeting in February 2014. Council has agreed 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 and that a report would be provided to Council in March 2015.</td>
<td>PSA are kept up to date with progress in this area and regular meetings are help with other regulators in order to learn from them. Two stakeholder consultations have now taken place and the reports are due to the March 2015 meeting of Council.</td>
<td>2 4 8</td>
</tr>
<tr>
<td>Failure to meet the required standard in all areas of the PSA performance report.</td>
<td>4 4 16</td>
<td>The PSA performance report identified standards which had not been met for the 2013/14 period. These were bought to the PSA's attention as the GCC had carried out an audit of case files in February 2014 covering the 2013/14 period. The committee noted at its last meeting that the concerns raised were housekeeping issues and that an action plan had been put into place. Since then the GCC have received the PSA initial stages audit which covered the cases closed in 2013/14 period and therefore contains largely the same failings as identified in the GCC's own audit of cases. There are also comments in relation to the IC decisions. The GCC have made changes to the FtP 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.</td>
<td>The GCC will be introducing a system of audits/reviews during 2015 and will include a benchmark review of the timescales that other regulators work to in the FtP system.</td>
<td>3 4 12</td>
</tr>
<tr>
<td>Risk of information security breaches of data</td>
<td>4 4 16</td>
<td>The organisation 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 FtP team have attended a seminar by a firm of solicitors.</td>
<td>The PSA Initial stages audit has identified a number of low level data protection breaches which had not been picked up by staff. This enhanced training provided in September 2014 for all members of staff along with the fact that the increase in the senior level staff members in the FtP team should reduce this during the next year. We will be carrying out an information governance audit in 2015.</td>
<td>2 4 8</td>
</tr>
<tr>
<td>Failure to uphold confidence in the GCC</td>
<td>3 4 12</td>
<td>Council had agreed to widen the exposure of our communication messages across a variety of online media. To help to implement this the GCC have appointed a Policy and Communications Manager in 2014.</td>
<td>Council considered the review of social media strategy in December 2014.</td>
<td>2 4 8</td>
</tr>
<tr>
<td>Failure to ensure compliance with all relevant legislation including the Equality Act</td>
<td>4 4 16</td>
<td>The Equality and Diversity policy which encompasses the functions of the organisation has been reviewed.</td>
<td>DH</td>
<td>An initial audit of the requirements upon the GCC in meeting the Equality Act has taken place and a number of short term measures had been recommended. The executive has started the implementation of these recommendations. Training for both Council and Senior executive team took place in 2014. Further training for all staff will be completed in February 2015. An E&amp;D champion has been nominated from the staff team and will meet the SEB to discuss E&amp;D issues across out statutory functions. Induction training has been provided to the employee.</td>
</tr>
<tr>
<td>Failure to manage changes in financial activity leading to capital withdrawals from the investment portfolio.</td>
<td>3 3 9</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>PG</td>
<td>Cazenove gave a presentation to Council in December which reported strong performance as at 25 November on the capital appreciation and income realisation. Council also agreed budget for 2015 at the same meeting.</td>
</tr>
<tr>
<td>Failure of Council to work effectively and make policy decisions in the public interest</td>
<td>3 4 12</td>
<td>Council has reviewed its performance by way of an effectiveness survey and at a seminar session in August 2014.</td>
<td>Chair</td>
<td>Council approved the terms of reference between Council and the executive along with the Scheme of Delegation and financial procedures at its meeting in February 2014. The complete governance handbook will be reviewed by Council in March 2015.</td>
</tr>
<tr>
<td>Failure to uphold standards</td>
<td>3 4 12</td>
<td>The COP/SOP review is currently being undertaken by a contracted third party and the first report was considered by Council in December 2013. Work is continuing in line with the project plan. There are a number of strands of work which need to be incorporated into the review such as the Duty of Candour, Francis Inquiry recommendations, Implied consent and the report into the FtP cases at the GCC since 2010.</td>
<td>PB</td>
<td>Council will review the proposed COP/SOP at a seminar session in March 2015 prior to its meeting.</td>
</tr>
</tbody>
</table>
### Council work plan for 2015

<table>
<thead>
<tr>
<th>March 31st</th>
<th>June 18th</th>
<th>September 30th</th>
<th>December 3rd</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Update report from the Audit Committee</strong></td>
<td><strong>Update report from the Audit Committee</strong></td>
<td><strong>Update report from the Audit Committee</strong></td>
<td><strong>Update report from the Audit Committee</strong></td>
</tr>
<tr>
<td><strong>Review of Strategic Risk Register</strong></td>
<td><strong>Strategic Risk Register - any items scoring over 15</strong></td>
<td><strong>Review of Strategic Risk Register</strong></td>
<td><strong>Strategic Risk Register - any items scoring over 15</strong></td>
</tr>
<tr>
<td><strong>Performance Report</strong></td>
<td><strong>Performance Report PSA - Annual FtP report and statistics</strong></td>
<td><strong>Performance Report</strong></td>
<td><strong>Performance Report</strong></td>
</tr>
<tr>
<td><strong>Board effectiveness</strong></td>
<td><strong>Non practising Register</strong></td>
<td><strong>Review Strategic Statement</strong></td>
<td><strong>Financial Strategy Review incl Investment Strategy</strong></td>
</tr>
<tr>
<td><strong>Budget update</strong></td>
<td><strong>Management letter and letter of representation</strong></td>
<td><strong>Communication Plan</strong></td>
<td><strong>Remuneration Committee's report</strong></td>
</tr>
<tr>
<td><strong>CPD/Continuing FtP</strong></td>
<td><strong>Financial Statements</strong></td>
<td><strong>Draft Business Plan and budget</strong></td>
<td><strong>Draft business plan and budget</strong></td>
</tr>
<tr>
<td><strong>CoP and SoP Update</strong></td>
<td><strong>CoP &amp; SoP Approval</strong></td>
<td><strong>Review of retention fees</strong></td>
<td><strong>Education Ctte annual report</strong></td>
</tr>
<tr>
<td><strong>Review of Governance manual</strong></td>
<td><strong>Update on research projects</strong></td>
<td><strong>Poss AECC recognition approval</strong></td>
<td><strong>Council Annual Effectiveness survey</strong></td>
</tr>
<tr>
<td><strong>Remuneration Committee paper</strong></td>
<td></td>
<td><strong>Poss Welsh Language Standards</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Annual Report and Accounts</strong></td>
<td></td>
<td></td>
<td><strong>Presentation from Cazenove</strong></td>
</tr>
</tbody>
</table>

### ITEMS TO NOTE

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

<table>
<thead>
<tr>
<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>
</tr>
<tr>
<td>Minutes from Education Ctte</td>
<td>Minutes from Education Ctte</td>
<td>Council dates for 2016</td>
<td>Minutes from Education Ctte</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Minutes from Audit Ctte</td>
</tr>
</tbody>
</table>