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

<table>
<thead>
<tr>
<th>Item</th>
<th>Action</th>
<th>Presenter</th>
<th>Paper</th>
<th>Time</th>
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<tbody>
<tr>
<td>1. Apologies and declarations of interest</td>
<td>to note</td>
<td>Chair</td>
<td></td>
<td>09.30</td>
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<tr>
<td>2. Council minutes of 7 December 2017 and matters arising</td>
<td>to approve</td>
<td>Chair</td>
<td>1803/2</td>
<td>09.35</td>
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| 3. Chair’s report
  • Remuneration Committee appointment
  • Appointment of Professional Conduct Committee and Health Committee Chair | to note, to approve | Chair | 1803/3 | 09.40 |
| 4. Executive report | to note | CER | 1803/4 | 09.50 |
| 5. Performance report
  • Monitoring of progress against Business Plan | to note | DCE SMT | 1803/5 1805/5A | 10.00 |
| 6. Recovery of costs associated with issue of certificates of good standing | to consider | Reg. Mgr. | 1803/6 | 10.20 |
| 7. Finalisation of revised and updated Indicative Sanctions Guidance for the PCC and HC | to approve | CER | 1803/7 1803/7A | 10.30 |
| 8. Item withdrawn from agenda | | | | |
| 9. IR(ME)R Explanation Guides | to consider | Dir. Edu | 1803/9 | 10.40 |
| **Break** | | | | |
| 10. Annual report and accounts – process and timeline | to note | DCE | 1803/10 | 11.10 |
| 11. Annual Registrations report | to note | Reg. Mgr. | 1803/11 | 11.20 |
| 12. Annual Fitness to practise report | to note | Bus. Officer | 1803/12 | 11.40 |
| 13. Annual Equality and Diversity report | to note | Bus. Officer | 1803/13 | 11.50 |
| 14. Report from Audit Committee | to note | AC Chair | oral | 12.00 |
| 15. Strategic Risks | to consider | AC Chair/ CER | ---- | 12.15 |
| 16. Report from Education Committee | to note | EC Chair | oral | 12.45 |
| 17. AOB
  • Questions from observers | to agree | Chair | | 13.00 |

Date of next meeting: 27 June 2018
MINUTES OF THE MEETING
OF THE GENERAL CHIROPRACTIC COUNCIL
HELD ON 7 DECEMBER 2017
44 WICKLOW STREET, LONDON WC1X 9HL

OPEN SESSION

Present
Mary Chapman (Chair of Council)
Tom Greenway
Steven Gould
Gareth Lloyd
Sharon Oliver
Ralph Pottie
Liz Qua
Keith Richards
Julia Sayers
Carl Stychin
Gay Swait
Phil Yalden

Apologies
Roger Dunshea

In attendance
Rosalyn Hayles, Chief Executive and Registrar
Paul Ghuman, Deputy Chief Executive (Director Resources & Regulation)
Amanda Greenlees, Executive PA

Observers
Mark Muncila (United Chiropractors Association)
Hilary Royall (McTimoney College of Chiropractors)
Michael Toft (Professional Standards Authority)
Niru Uddin, Head of Investigations (GCC)

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<thead>
<tr>
<th>C-1712/1</th>
<th>Apologies and declarations of interest</th>
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<td></td>
<td>The Chair welcomed Council and the observers to the meeting. She said she had hoped that Council member Roger Dunshea would be able to join by phone but unfortunately that had not been possible so he was noted as absent from the meeting.</td>
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<td></td>
<td>Council member Phil Yalden declared an interest in item C-1712/8 ‘Education Report’, as he works for an education provider.</td>
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**C-1712/2**

Draft minutes of the meeting of 20 September 2017 and matters arising.

The minutes of 20 September 2017 were agreed as an accurate record of the meeting. There were no matters arising.

**C-1712/3**

Chair’s report

The Chair’s report provided an update on the work carried out by the Chair from September, detailing her meetings with representatives from the associations, the Royal College of Chiropractors, chairs of other regulators and the PSA.

**C-1712/4**

Executive report

The Chief Executive and Registrar introduced the executive report, which provided an update on work carried out since the September Council meeting.

In answer to a query about the check of registrants’ CPD summaries for 2015/16 (which were still being carried out) and how that compared with previous years, the CER explained that this was the first time a full audit of the quality of CPD submissions has been carried out, so there was no previous year to compare to. When asked whether registrants would be removed from the register if they continued to be non-compliant, the CER said that she hoped the reminder letters recently sent would result in their complying but otherwise as Registrar she would need to make a decision on next steps to be taken with regard to each individual, possibly seeking external advice.

Council noted that the first sentence of number 3. of the paper, which read "The Education Committee has provided its Annual Report to the Committee....." should read ""The Education Committee has provided its Annual Report to the Council.....".

The Chair asked the CER to inform Council of the impact on the GCC of the reduction in the PSA’s proposed levy for 2018/19.

**Action: CER to provide Council with information about the impact on the GCC of the reduction in the PSA’s proposed levy for 2018/19**

**C-1712/5**

Performance report

Financial summary

The DCE introduced the Performance report. He said that the main change in performance to-date was that fitness to practise (FtP) costs were far greater than anticipated and that a note in the paper explained the variance. He said that the GCC was not hitting their revised target of determining Investigating Committee (IC) cases from receipt of the complaint within a median of 28 weeks, but that the median had improved from 34 to 31 weeks. He said 75% of cases were within 4 months and that the GCC was moving closer to meeting the target. It was suggested that the next performance report should provide the comparator median looking back. In response to a query about the increase of adjournments, the DCE explained that adjournments are due to various issues, including late service of evidence. In one case an expert was taken ill at short notice which led to an adjournment.

Council discussed the change to holding IC meetings over two days instead of one and noted this had contributed to a significant costs increase. The DCE explained that the two-day meetings allowed for decision-making and the agreement of allegations to be done at the time (rather than agreed by email later on) so that all
parties could be advised of the outcome promptly. In discussing the cost-benefit of the new system, the DCE said there would be a review of whether two-day IC meetings were necessary in every case. The CER added that, in addition to the points raised by the DCE, the two-day meetings had also been put in place in order to improve the quality of the decisions made, as this had been an issue in the past when the IC was under pressure to complete consideration of a large volume of cases in one day.

C-1712/6 Appointment of additional Investigating Committee panel chairs

The DCE introduced this paper which asked that Council a) agree the appointment of three IC panel chairs and b) agree the reappointment to the IC of the three individuals specified.

The DCE explained that the new appointments were being sought in order to increase the number of IC panel chairs, otherwise difficulties arose in relation to registrants who had multiple complaints about them. He also said that the GCC would need more capacity at IC panel chair level during 2018 due to the need to process the large caseload of advertising cases. He confirmed that positive peer feedback had been received regarding the candidates put forward as IC panel chairs, from the time when they acted as PCC Chairs.

Council agreed the reappointments of Eileen Carr, Jill Crawford and Lubna Shuja to the IC and to their appointment as IC panel chairs.

C-1712/7 Revised guidance on advertising by chiropractors

The CER introduced the paper on the GCC’s revised guidance on advertising, which Council was asked to agree. The CER explained that the GCC had been engaging with the Advertising Standards Authority (ASA) throughout 2017 to update the GCC’s existing guidance so that it was both more reflective of the guidance recently published by the ASA and also to improve its clarity.

She said that the new guidance document ‘Guidance on Advertising to the Public’ (at Appendix A) had been shared with the professional associations and the Royal College of Chiropractors. Feedback from the RCC and ASA had been incorporated. The professional associations had not commented.

Council noted that individual chiropractors may struggle with aspects of the ASA’s guidance. They discussed dissemination of the GCC guidance and the importance of getting the message about advertising across to individual registrants. It was proposed that the GCC could maintain the messaging around the importance of complying with advertising requirements by highlighting individual sections of the Guidance in monthly newsletters, and that the newsletter could also remind registrants that they can seek advice from the CAP Copy Advice Team. It was suggested that it would be helpful for the website version of the guidance to allow readers to click on individual headings or subheadings. Council members also suggested that the GCC consider channels of communication in order to enhance registrants’ engagement with the content of the Guidance.

The CER said that the ASA had indicated they might produce a new webinar about their guidance, which the GCC could then advise registrants about.

Council members suggested amendment of the document so that its purpose is stated at the forefront. The CER explained that the front part of the Guidance was in a GCC standardized format for such guidance and suggested that any suggested changes would have to be applied to all GCC guidance documents. This could be
considered by the Director of Education, Registration and Standards.

Council agreed to publication of the revised Guidance.

**Action:** The Director of Education, Registration and Standards to review the format used for GCC guidance documents

### C-1712/8 Report from the Education Committee

The Chair of the Education Committee (EC) introduced the Education Committee report for the purpose of informing and updating Council on the work that had been undertaken by the EC during 2017, including: annual monitoring of education providers; reviewing the Test of Competence (ToC); assuring continuing FtP; reviewing the Degree Recognition Criteria and Quality Assurance System; assessing pre-registrant professionalism; researching the preparedness of students for practice; and carrying out a review of the guidance for education providers and students on student fitness to practise and student health and disability. The EC Chair noted that some of the processes would be reviewed and refined, especially those processes that were new. She said she expected there would be quite a heavy workload with possible new providers and the work required around that.

The Chair of Council asked the EC Chair for a general comment on demand and supply in chiropractic education and the EC Chair said that there was certainly a disproportionate geographical spread of available places, so it was unclear what the true demand was with insufficient evidence to confirm whether more places were needed in total for UK students. She said more work was needed on this to ascertain true demand and strike a balance between this and supply in order to allow for expansion of the profession across the country but also to retain a high level of standards in education provision.

### C-1712/9 Report from Audit Committee

The Chair of the Audit Committee (AC) provided Council with an update on the Audit Committee’s work. She said that the AC had reviewed its Terms of Reference (ToR) and that, once these had been agreed, they would be put before Council for agreement. She said that the AC had reviewed the Strategic Risk Register and found no risks scoring over 15. She noted that the AC would be looking to amend some of the wording on the risk register and that some small amendments had already been made.

The AC Chair said the Committee was of the view that it would be beneficial, in view of ensuring continued business, for it to have two independent members, due to the mandatory requirement for the independent member to be present at meetings. The Chair asked Council to approve this proposal. Council discussed the proposal and agreed that the risk of only having one independent member was low compared to the cost of recruiting a new member. Council decided that the AC should continue to have only one independent member, but that this should be reviewed at the end of that independent member's term, in 2019. Council agreed that the Executive should compile a list of external persons who would be suitable independent members in the event that the GCC needs to co-opt an independent member to attend a particular meeting in future.

The AC had reviewed the Bevan Brittan FtP audits and had asked for a more targeted audit for 2018, one that focused on areas highlighted as problematic in the PSA reports. The AC had also reviewed the registrations audits and had agreed to
review the approach to the audit for 2018 at its next meeting.

The AC had reviewed the external financial auditor's performance and the Committee were satisfied with the work carried out. The AC Chair noted that the audit partner would change in 2019, as they had now completed the maximum term of 8 years.

The AC recommended that, due to the number of new Council members, Council members should receive training on the role of the Audit Committee and on risk management.

The Audit Committee considered that they were operating effectively and within the current ToR. The AC had also agreed that internal audit assurance should be reviewed in the next twelve months after the Strategic Statement and Business Plan have been finalised.

The AC had agreed its workplan for 2018, which would include a review of the risk management strategy in February 2018.

The AC had also asked the Executive to bring to its next meeting a proposed KPI in relation to the advertising caseload, having decided what the appropriate start and endpoint should be in terms of measuring performance.

Audit Committee meeting dates for 2018 had been agreed and were confirmed as 22nd February, 31st May and 22nd November. The AC minutes would be circulated with the Council minutes.

The Chair of Council suggested that the Council should reconsider the approach to risk within the Council at the March 2018 Council training session, including considering how the Council should work with the Audit Committee in regard to risk identification and appetite for risk. This would enable Council to provide clear delegations to the AC and to the GCC staff in terms of establishing risk mitigations and monitoring timetables. In this way Council could be more appropriately involved in matters of strategic risk for the organisation.

At that session, Council would also agree the purpose of the investment funds and decide what those funds could properly be used for.

**C-1712/10 Strategic Statement for 2018-2020**

Council agreed to adopt the Strategic Statement, incorporating minor amendments which it had discussed in its closed session. In particular, Council had agreed to reword Strategic Objective 1 from "Encouraging professionalism (and thereby improving public protection and the quality of patient care)" to "Enhancing professionalism in order to improve public protection and the quality of patient care and to maintain public confidence in the profession".

**C-1712/11 Business Plan for 2018**

The Chair began by noting that there were a number of new Council members (including herself) and that the CER had only been in post nine months when work began on the Business plan for 2018, so work that would have ordinarily been carried out over a year had been compressed into the last three months. That being the case, she said there may be areas that needed more fine tuning before the business plan could be agreed.

The DCE said that the Executive had not, as yet, considered the budget and
resourcing implications of the plan and he said the action plan also needed to be considered. The Chair asked Council whether they agreed that the plan included all the necessary elements needed in order to achieve the strategic objectives. She also asked whether Council wanted to put forward ideas about what items should be considered priorities/should be prioritised on the business plan.

Council also agreed that clearer performance measures should be introduced so that progress could be tracked against the Business Plan.

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<tr>
<th>C-1712/12</th>
<th><strong>Budget for 2018</strong></th>
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<tr>
<td>The DCE introduced the draft budget paper, which was in two sections – the first contained the 2017 budget, the proposed 2018 budget and the movement between the two and the second section contained the year-end forecast for 2017, the proposed budget for 2018 and the movement between the two. The budget had been prepared on the basis of Council not yet having agreed the 2018 business plan or the 2018-2020 Strategic Statement.</td>
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<td>The DCE spoke of the difficulty of completing a budget in the absence of a business plan having been agreed and so spoke of the need over the next weeks to arrive at a position from which Council was content to proceed. He said that the journey to a break-even budget was not yet complete but that the GCC was moving in the right direction.</td>
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<td>The DCE referred to the paper. He noted that the primary difference since the start of 2017 was that there had been a reduction in staffing costs of approximately £200k and that as a consequence a large number of PCC cases had been referred to external lawyers. The external legal costs had therefore been higher than anticipated. The 2018 budget had been forecast similarly and the GCC were still looking at a deficit of £155k once consultancy fees were included. Council felt that there was category confusion over some items, particularly consultancy fees, and that clarity was needed in order to determine which items were optional and which were not.</td>
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<td>Council agreed that it would be useful to examine the consultancy project list to see which of those projects are necessary in order for the GCC to fulfil its statutory duties, which don’t fall into that category and can be re-examined and whether the estimated costs can be reduced or more cost-effective ways found to deliver them. Council agreed that the detailed paper was helpful and agreed the intention of moving toward a break-even budget position. Council agreed that the GCC staff should review the budget and re-present the budget to Council via email before the end of the year.</td>
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<td>A Council member noted the absence of a work plan under AOB and the Chair explained that the work plan was a GCC staff issue and, as such, was not necessary to include as part of Council business.</td>
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<td>Council also thanked the Executive for all their work on the papers and on the governance work.</td>
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<td><strong>Questions from observers</strong></td>
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<td>The Chair invited the observers to ask any questions they had.</td>
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<td>The UCA representative asked whether the late disclosure of evidence referred to when discussing adjournments involved the defence bodies. The CER confirmed that</td>
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it did and the representative said he would take that information back to his organisation.

In answer to the query about the break-even budget position and external costs for FtP, the CER explained that preparation of cases for PCC hearings had been outsourced after staff departures from the organisation, as an interim measure to ensure continued throughput of cases pending longer-term consideration of whether to replace the staff or to outsource permanently. It is now anticipated that tendering for provision of external legal advice will result in cost savings going forwards.

The question was raised about whether the GCC had a responsibility for success or failure of chiropractic degree programmes. The EC Chair explained that the GCC’s role is to assess the extent to which courses match the requirements and standards set by the GCC.

Date of next meeting: 21 March 2018
### Actions from December 2017 meeting

<table>
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<tr>
<th>Action</th>
<th>Person responsible/ date to be completed by (if other than by next Council meeting)</th>
<th>Status</th>
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<tbody>
<tr>
<td>CER to provide Council with information about the impact on the GCC of the reduction in the PSA’s proposed levy for 2018/19</td>
<td>CER</td>
<td>Completed</td>
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<tr>
<td>The Director of Education, Registration and Standards to review the format used for GCC guidance documents</td>
<td>The Director of Education, Registration and Standards</td>
<td>Format will be reviewed for next edition of advertising guidance.</td>
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**Other actions:**

The revised Strategic Statement and the amended Business Plan was approved by Council in January 2018.
Introduction

1. In the period since the last Council meeting, my priority has been to ensure the continuity and quality of the GCC’s executive leadership and in other roles which contribute to fulfilling the GCC’s statutory duties. I have also taken opportunities to develop further relationships with other stakeholders.

Staff

2. Following the resignation of Rosalyn Hayles, Council decided at the special meeting on 19th January to recruit an interim CER. This process has now been concluded and a full report will be provided in the private meeting of Council.

Council and Committees

3. Following the re-appointment process agreed by Council, I am delighted to report that the Privy Council has confirmed our proposal to reappoint Carl Stychin for a five year period from 31st January 2018.

4. The process has commenced to consider the re-appointment of Phil Yalden.

5. Following consideration of HR professionals, a proposal has been made to Council for the appointment of a new independent member of the Remuneration Committee.

6. Following a selection process, a recommendation was made to Council for the appointment of an overall Chair of the Professional Conduct and Health Committees. Council has agreed the recommendation and the appointment will be made in w/c 19th March.

7. The 2018 round of Council members’ appraisal was commenced. This will be phased through the year broadly in line with appointment dates.
Stakeholders

8. The GCC hosted the bi-annual meeting with the Professional Associations and the RCC. It was an opportunity to share understanding about the Department of Health’s consultation and the approach to the Allied Health Professions Officer, as well as discussing specific regulatory issues.


10. The CER and I met with Claire Armstrong, Department of Health, to reinforce some of the key messages in our response to the Consultation.

11. I met with Peter Dixon, President of the RCC, in follow up to the conference.

Induction

12. I attended, as an observer, the training day for Investigating Committee members.

13. I met with Adam Halsey, Audit Partner with haysmacIntyre, to discuss the proposed contribution to the Council training day.

Governance

14. Following an exchange of correspondence with the Privy Council, we have received advice to the effect that there is no objection to the GCC leaving posts vacant if a vacancy arises provided that we retain an approximate balance of lay and professional members and that we have sufficient members to be quorate and people our committees. This is following their agreement that the GCC Council is larger than is considered effective and that the matter of board composition is included in the current Government consultation.
Council is asked to note the contents of the report.

Introduction

1. This report outlines delivery of the GCC’s statutory functions in the period since the Council last met. It also summarises developments in the external regulatory environment, including collaborative work with other regulators in the sector.

2. Performance against Key Performance Indicators and progress against business plan activities is reported separately in the Performance Report.

Education and Training

Education Committee

3. The Education Committee met on 12 and 13 March 2018. The Chair of the Education Committee will report into Council.

Test of Competence

4. On 25th January 2018 nine candidates undertook the Test of Competence interview. Of those candidates, two passed, two were asked to submit further evidence to allow further consideration of their applications and a further five failed. Substantial feedback has been provided to those candidates who failed, which we hope will prove helpful should they wish to re-sit the test in the future.

5. Three candidates have applied to sit the next Test of Competence on 15 March 2018.

6. The TOC External Examiner’s report, along with the GCC Response, was presented to the Education Committee on 12th March and both will be published on the GCC website.

Standards and Guidance

Research

7. As previously reported, the report into new graduates’ preparedness for practice was finalised for publication (alongside an Executive Summary and a Summary report) in early
2018. These have been shared with key stakeholders and key findings from the work were discussed with the UK chiropractic education institutions during their attendance at the Education Committee meetings on 12 and 13 March.

Fitness to Practise

8. The hearing of a registrant appeal against the outcome of a Professional Conduct Committee (PCC) case (as previously reported to Council), took place on 31 January 2018. The High Court rejected the registrant’s appeal and upheld the Professional Conduct Committee’s decision. The registrant was ordered to pay the GCC’s costs of defending the appeal.

9. The public consultation on an updated version of the Indicative Sanctions Guidance commenced in December 2017. A separate paper to be considered by the Council at this meeting summarises the comments made during the consultation period and sets out recommendations as to the final wording of the revised Guidance document. Any significant changes in the revised document compared to the version currently in operation will be highlighted to members of the Professional Conduct Committee at their forthcoming training session, before the revised document is brought into effect.

10. As previously reported to Council, expressions of interest in taking on the role of overall Chair of the PCC and the Health Committee were invited from the panel chairs of the Professional Conduct Committee. Following that process, the Chair of Council along with another lay member of Council interviewed the candidates who put themselves forward. A separate paper to be considered by the Council at this meeting sets out the recommendation they make to the Council about the appointment of an overall Chair of the PCC and Health Committee.

11. Members of the Investigating Committee attended a training day organised by the GCC on 19 February, at which external trainers presented on unconscious bias and recent relevant case-law. The CER also updated the Committee on the GCC’s plans to introduce a new guidance document setting out the Investigating Committee’s role, as provided for in the statutory framework.

12. All registrants who are the subject of complaints made in 2015 and 2016 about advertising claims made on their practice websites have now been notified and have received further letters from the GCC explaining the next step of the investigation process. The Deputy Chief Executive (Director of Resources and Regulation) is overseeing the management of the FTP team’s project plan to progress consideration of these complaints by the Investigating Committee during 2018.

13. The draft GCC annual report on fitness to practise activity is the subject of a separate paper for Council’s consideration.

Registration

14. The draft GCC annual report on registrations is the subject of a separate paper for Council’s consideration.
Checks of registrants’ CPD summaries

15. The process of checking all registrants’ CPD summaries for 2015/16 concluded in February. A small number of registrants at that time had not fully engaged with the process. The CER has written to each of them individually highlighting the difficulties with their CPD submissions and advising some of them that their CPD for both the 2016/17 and the 2017/18 periods will be reviewed.

16. The Registrations Manager, CER and Director of Education, Registration and Standards have liaised on the format of the process to be used to review a sample of the 2017/18 CPD summaries, taking account of the learning the Registrations team derived from the exercise of reviewing every single registrant’s CPD summary for the 2015/16 year. Information about the process that will be used in relation to the 2016/17 CPD summaries was provided in the newsletter sent out at the start of March.

Database developments

17. In the Executive report supplied for the previous Council meeting we outlined three database developments that were under way. No further progress has yet been made with the development to assist random selection of registrants for CPD checks is set out below, pending the completion of other work by the developers.

Action taken in respect of convictions that were previously not referred to the Investigating Committee

18. As previously reported to Council, the checks that were undertaken in 2017 to establish the number of previous conviction matters that were not referred to the Investigating Committee (as they should have been) identified 27 such matters.

19. At the date of the last Council meeting, 8 of those matters had been passed over to the fitness to practise team to progress to the Investigating Committee and a further 7 matters were under ongoing review. In addition, another 12 matters (concerning speeding offences) have been handed over to the fitness to practise team.

Communications and engagement with stakeholders

Engagement with professional stakeholders

20. The Chair, CER and the Director of Education, Standards and Registration hosted a joint meeting with the four chiropractic professional associations and the Royal College of Chiropractors on 2 February 2018. At that meeting the CER outlined the legal framework that governs the GCC’s handling of fitness to practise concerns and summarised the steps that the GCC has taken in regard to the complaints made about advertising on chiropractors’ websites. The Chair and CER subsequently wrote to each professional association responding to questions they had raised in advance of the meeting.

Engagement with other regulators

21. The CER and the Director for Education, Registration and Standards attended a regulatory conference hosted by the GMC on 6 March 2018. The event focused on use of
data to drive effective interventions for the benefit of patient safety, shifting regulator’s focus to support professionalism “upstream” and providing regulatory support for professional education.

22. The Director for Education, Registration and Standards attended the annual Professional Standards Authority’s academic conference on 8 and 9 March 2018. The theme was fitness to practise, including student fitness to practise, and was jointly chaired by the PSA and Professor Tim David from the University of Manchester. Sessions looked at current issues and understanding complaints and motivation and workshops considered maintaining fitness to practise, FTP analysis, sexual misconduct, regulation and the workforce and behaviour change. It was attended by over 100 academics and regulatory staff from the UK and internationally.

Engagement with government

23. The Chair of Council and the CER met with the Deputy Director of the relevant Department of Health team on 21 February. At that meeting the urgency of achieving modernisation of the GCC’s legislative framework was a key topic discussed. It is clear that due to the current legislative challenge facing the Government in terms of securing an orderly withdrawal from the European Union, there will be little, if any, Parliamentary time available in the short term for consideration of proposals for reform to the professional regulators’ frameworks. There may however be an opportunity for change to statutory rules in the medium-term, and that possibility will be factored into the GCC’s business planning for 2019 and subsequent years.

24. The CER and Director of Education, Registration and Standards met with the Deputy Allied Chief Health Professions Officer on 21 February to share information about the statutory regulation of chiropractors by the GCC. That meeting was the first of several individual meetings that have been scheduled by the Deputy Allied Chief Health Professions Officer with each of the professional associations and the Royal College during February/March.

25. The CER attended a meeting of all the regulators with the Department of Health on 9 February (convened by Department of Health officials) to discuss the potential arrangements that will need to be put in place to manage the impact on the regulators’ registration processes of the UK’s exit from the EU.

26. The CER attended a seminar run jointly by the Welsh Government and the PSA in Cardiff on 15 February on regulatory developments and the Welsh context.

Governance, finance and operational activities

27. The GCC’s Strategic Statement for the period 2018-2020 and its Business Plan for 2018 were published on the website in February, following finalisation by the Council.

28. Annual training for the Investigating Committee took place on 19 February 2018. The Professional Conduct Committee (PCC) members’ annual training day is planned for 26 March 2018. The training included (or will include) unconscious bias and case-law
updates, as well as information about guidance under development by the GCC that
directly relates to the Committees’ work.

29. Council are being asked separately at this meeting to approve the appointment of an
overall Chair of the PCC (and Health Committee) following completion of a recruitment
process led by the Chair of Council and supported by the CER.

30. The Council Member whose appointment was due to come to an end in January 2018
was reappointed by the Privy Council with effect from 31 January, following a
recommendation made by the Reappointments Committee. A reappointments process in
respect of a further Council Member whose appointment is due to come to an end during
May 2018 is now under way.

31. The Professional Standards Authority (PSA) notified the GCC in March that it had begun
the performance review process and that the GCC could expect to receive notification on
around 16 April as to whether or not the PSA would need to carry out a targeted or
detailed review, before it reaches a decision about whether or not the GCC met all the
Standards of Good Regulation in 2017/18.

External developments

Regulatory reform

32. The Department of Health’s consultation on reform of the health and care professions
regulators closed on 23 January 2018. The GCC’s response was finalised with input from
Council members. A copy of it was sent to the Deputy Director within the relevant team at
the Department of Health under cover of a separate letter emphasising the urgency of
modernisation of the GCC’s legislative framework. It is understood that a large number of
responses to the consultation were received. There is as yet no clear timetable for the
Government to issue its response to the consultation.

Advertising Standards Authority guidance

33. The GCC has been disseminating information about the ASA guidance on advertising of
chiropractic services issued in November 2017 and about the GCC’s revised guidance in
each monthly newsletter in 2018, as suggested by the Council at its meeting in December.
The professional associations were, at the joint meeting with the GCC and the RCC in
February 2018, invited to share information about their activities to promote compliance
with the guidance with the GCC, so that the GCC can also highlight in future newsletters
the support available to registrants on this topic from their professional associations.

Collaboration with the other health and care professions regulators

34. Members of the Executive attend the regular cross-regulatory groups focused on:
Standards; Governance; Resources; Fitness to Practise; CPD/Continuing Fitness to
Practise, Horizon Scanning and Performance. In addition the CER attends the Chief
Executives Steering and Legislation Group meetings at which useful information is
shared. The most recent such meetings took place on 20 March (CESG).
To: General Chiropractic Council
From: Paul Ghuman, Director of Resources and Regulation
Subject: Performance report for February 2018
Date: 21 March 2018

Purpose
1. The purpose of the report is to present to Council the Performance report covering the period to 28 February 2018.

Background
2. Council agreed on the format of the report to include an overview front page, a financial summary, and an exception based KPI report along with a report of the business plan activities for the year.

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

Financial implications
4. These are highlighted in the report.

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

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

Communications Implications
7. There are no communications implications arising from this paper.
Performance Management and monitoring of the business plan

February 2018

Prepared by the Deputy Chief Executive (Director of Resources and Regulation)
Overview

**Major Events**

These have been reported in the reports by the Chair and Chief Executive earlier on the agenda.

**Business Plan delivery**

Council agreed that the GCC’s Executive should report on any activity that was not proceeding as planned.

**Key Performance Indicators**

We are not hitting our target of determining IC cases from receipt of the complaint within a median of 28 weeks. The current median is 30 weeks.

**Financial**

The net positive difference on income is £17k to date. There is a positive difference on annual retention income of £2k, a positive difference of £11k on investment income and a further positive difference on initial registration of £5k to date.

Expenditure to the end of the February 2018 is lower than forecast by £74K. This is primarily, as a result of a large positive variance of £51k to date on FtP costs. This is due to the relatively low number of PCC cases in this period to date although advertising costs are higher than expected as a result of a collated expert report on all conditions. There are some smaller positive variances on staff costs of £6k and also £10k on professional fees to date.

The overall surplus at the end of February 2018 is £91K.
# Financial Summary – As at 28 February 2018

## Income

<table>
<thead>
<tr>
<th>Sales</th>
<th>Actual</th>
<th>Budget</th>
<th>Difference</th>
<th>2018 Budget</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Registration</td>
<td>32,550</td>
<td>27,200</td>
<td>5,350</td>
<td>112,500</td>
<td>1</td>
</tr>
<tr>
<td>Non practising to practising</td>
<td>1,600</td>
<td>1,600</td>
<td>0</td>
<td>8,800</td>
<td></td>
</tr>
<tr>
<td>Restoration</td>
<td>5,350</td>
<td>6,750</td>
<td>-1,400</td>
<td>14,250</td>
<td></td>
</tr>
<tr>
<td>Retention - Practising</td>
<td>2,340,000</td>
<td>2,336,800</td>
<td>3,200</td>
<td>2,336,800</td>
<td>2</td>
</tr>
<tr>
<td>Retention - Non Practising</td>
<td>26,100</td>
<td>27,000</td>
<td>-900</td>
<td>27,000</td>
<td>3</td>
</tr>
<tr>
<td>Investment Income</td>
<td>42,397</td>
<td>32,000</td>
<td>10,397</td>
<td>192,000</td>
<td>4</td>
</tr>
<tr>
<td><strong>Income (A)</strong></td>
<td>2,447,997</td>
<td>2,431,350</td>
<td>16,647</td>
<td>2,691,350</td>
<td></td>
</tr>
</tbody>
</table>

## Expenditure

<table>
<thead>
<tr>
<th>Expenditure</th>
<th>Actual</th>
<th>Budget</th>
<th>Difference</th>
<th>2018 Budget</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Costs</td>
<td>152,805</td>
<td>158,848</td>
<td>6,043</td>
<td>961,088</td>
<td></td>
</tr>
<tr>
<td>IT costs</td>
<td>5,878</td>
<td>6,667</td>
<td>789</td>
<td>63,000</td>
<td></td>
</tr>
<tr>
<td>Office Costs</td>
<td>20,174</td>
<td>23,183</td>
<td>3,009</td>
<td>192,100</td>
<td></td>
</tr>
<tr>
<td>Accommodation Costs</td>
<td>28,129</td>
<td>30,167</td>
<td>2,037</td>
<td>215,000</td>
<td></td>
</tr>
<tr>
<td>Finance costs</td>
<td>2,316</td>
<td>1,233</td>
<td>-1,082</td>
<td>34,700</td>
<td></td>
</tr>
<tr>
<td>Professional fees</td>
<td>8,935</td>
<td>18,313</td>
<td>9,378</td>
<td>183,089</td>
<td>5</td>
</tr>
<tr>
<td>Council costs</td>
<td>21,383</td>
<td>24,167</td>
<td>2,783</td>
<td>165,000</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>336</td>
<td>400</td>
<td>64</td>
<td>3,500</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>173</td>
<td>0</td>
<td>-173</td>
<td>15,440</td>
<td></td>
</tr>
<tr>
<td>FtP</td>
<td>124,034</td>
<td>175,372</td>
<td>51,338</td>
<td>1,052,230</td>
<td>6</td>
</tr>
<tr>
<td><strong>Expenditure (B)</strong></td>
<td>364,163</td>
<td>438,349</td>
<td>74,187</td>
<td>2,885,147</td>
<td></td>
</tr>
<tr>
<td><strong>Surplus / (Deficit)</strong></td>
<td>2,083,835</td>
<td>1,993,001</td>
<td>90,834</td>
<td>-193,797</td>
<td></td>
</tr>
</tbody>
</table>

## Funding - Earmarked for Continuing Fitness to Practise

<table>
<thead>
<tr>
<th></th>
<th>Balance b/f</th>
<th>Income</th>
<th>Expenditure</th>
<th>Balance c/f</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>53,749</td>
<td>0</td>
<td>0</td>
<td>53,749</td>
</tr>
</tbody>
</table>

## Test of Competence

<table>
<thead>
<tr>
<th></th>
<th>Income</th>
<th>Expenditure</th>
<th>Balance c/f</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18,000</td>
<td>13,927</td>
<td>4,073</td>
</tr>
</tbody>
</table>
Note 1:
Initial registration income is slightly higher than expected to date by £5k. Students from one of the educational establishments graduate during this period and therefore we expect a large number of those to register with the GCC. Students from the other educational establishments graduate and register, primarily during the July to September period.

Note 2:
The main note for the February financial summary is whether the budget (£2,340,000) for practising retentions is in line with actual (£2,336,800). The actual is very close to the forecast and there is a positive variance of 0.13% (£3,200).

Note 3:
The number of people retaining either as non-practising is lower than budgeted. We expected income of £27k but actual receipt was £26.1k

Note 4:
Investment income performance is higher than budgeted at the end of February 2018. The investment income is primarily from income distributions from the investment portfolio.

In respect of above notes, the GCC has received 91% of the income forecast for the year, at the end of February.

Note 5:
Professional fees are slightly lower than forecast to date with fewer costs than expected incurred in relation to professional and consultancy fees. This is likely to even out over the next few months.

Note 6
FtP costs at the end of February 2018 are below forecast by £51k. This is simply a timing issue as there are only two PCC cases heard in the period.

The initial analysis of 300 plus advertising cases will mean that the large proportion of these cases will need to be determined by the IC during the course of the year. We have commissioned an expert report which collates the expert’s opinion on most of the claims which are subject to a complaint.

The GCC has received 12 (section 20) complaints to be determined by the Investigating Committee in February 2018. Last year, we had at this stage received 10 complaints.

Portfolio valuation
The portfolio value has fallen in February and was £4,805,820 as at 28 February 2018.
### Key Performance Indicators (reported by exception)

<table>
<thead>
<tr>
<th>Fitness to Practise</th>
<th>Status</th>
<th>Exception Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>To determine IC cases within a median target of 28 weeks from receipt of the complaint to determination by the IC.</td>
<td></td>
<td><strong>Actual rate</strong>&lt;br&gt;The median target for cases determined by the IC for the last 12 months is 30 weeks.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Reason</strong>&lt;br&gt;The reasons are that we have been processing a number of older cases, have moved to a more work intensive process by front loading of cases by taking witness statements and expert opinions where necessary at this initial stage of the investigation and also as a result of the increase in the number of complaints last year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Action</strong>&lt;br&gt;Monitoring arrangements were put in some time ago and the number of older cases in the pipeline has now reduced dramatically. The median has been reducing for some months and we hope to meet the target in the next 6 months.</td>
</tr>
</tbody>
</table>

### Business plan progress

A separate paper (1803/5A) has been prepared reporting on progress on the Business Plan project work due in Quarter 1 of 2018.
To: The Council, General Chiropractic Council  
From: Rosalyn Hayles, Chief Executive & Registrar  
Subject: Reporting on progress of Business Plan 2018 project work  
Date: 21 March 2018

Purpose

1. Council is asked to consider the schedule attached as Appendix A - which provides a report on progress against those projects within the Business Plan for 2018 that are due to be initiated/completed within Quarter 1. The schedule also identifies those projects due to commence in Quarter 2. Council is also asked to consider the recommendations made below.

2. Council is asked to advise whether the format of this report and the attached schedule is helpful or whether amendments are required for future reports.

Background

3. In the course of preparing the Business Plan for 2018, the executive provided Council with a detailed schedule identifying:
   - the strategic objective each activity principally relates to;
   - its overall aim;
   - the estimated timing for the activity’s initiation/completion;
   - any known inter-dependencies with other activities;
   - whether the activity is regarded as essential, important or desirable; and
   - the external costs associated with the activity, as reflected in the Budget for 2018. Where the resource used for the activity involves use of (existing) staff time, that is also noted.

4. Appendix A is an adaptation of that schedule – which shows the senior management team lead for each project, as well as an RAG status allocated by the CER on the basis of progress against documented project plans.

5. There are a small number of projects/ workstreams for which a separate project plan is not required – which are clearly identified in Appendix A (and which therefore are not RAG rated).

6. For all other projects, amber RAG status has automatically been allocated to any project which was due to commence in Quarter 1 and for which at this stage no documented project plan has yet been finalised.

7. Council will note that activity has already been initiated on some projects not due to start until Quarter 2 or later.

Recommendation

8. It is proposed that the CER should provide Council with a monthly update between Council meetings as to the status of those projects currently shown as having an amber (or red) RAG
status which are regarded as time-critical or which are otherwise regarded by the Council as being of particular strategic significance.

9. It is suggested that the relevant projects from the current Appendix A would be:
   - Reviewing the Disclosure Policy and general GDPR compliance
   - Planning for the office move
   - Tender for provision of external legal services (because of the potential for cost savings once this has been completed)

10. The first such monthly report would need to confirm that a written project plan is in place, and to report progress against delivery of key milestones

11. The senior management team recommends that Council reviews the entirety of the updated Appendix A at its June meeting along with the Budget for 2018, with a view to re-prioritising activities and/or resources for the second half of 2018 as considered appropriate at that time.

Equality and diversity implications

12. None have been identified.

Financial implications

13. There are no specific financial implications arising at this time. Were Council to decide to allocate additional financial resources to any project(s) in order to facilitate/expedite delivery, adjustment of the Budget for 2018 would need to be considered at that point in time.

Legal or Risk Implications

14. There are legal implications that would arise from failure to deliver some of the projects listed in Appendix A as commencing in Quarter 1 on time, including the projects that relate to GDPR compliance.

15. There are risks (financial and otherwise) that would arise from failure to deliver other projects due to start in Quarter 1 on time, including the projects to plan effectively for the office move and to tender for provision of external legal services.

16. It is recommended therefore that Council seeks additional assurance of the progression of these projects in advance of the next Council meeting, as set out above.

Communications implications

17. There are no direct communications implications arising at this time. Any ongoing failure to progress the projects on the Business Plan in subsequent Quarters would have the potential to result in criticism of the GCC by external stakeholders.

Action

18. Council is asked to consider Appendix A attached and the recommendations set out above, and to confirm whether it wishes to accept those recommendations.

19. Council is also asked to confirm whether it is content with the format of this paper and the attached Appendix A as the mechanism by which the executive should report progress on Business Plan projects going forwards.
<table>
<thead>
<tr>
<th>Activity ongoing or to be initiated in Quarter 1</th>
<th>Progress /delivery measures</th>
<th>Estimated initiation by quarter</th>
<th>Estimated completion by quarter</th>
<th>Inter-dependencies with other GCC activity</th>
<th>SMT member accountable for delivery</th>
<th>RAG rating</th>
<th>Comments re amber/red status including mitigations put in place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publication of Graduate Preparedness for Practice research report</td>
<td>Publication of report and subsequent discussion with education providers (Education Committee)</td>
<td>Quarter 1 2018</td>
<td>Quarter 1 2018</td>
<td>none</td>
<td>PB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developing guidance for continuing fitness to practise, based on outcomes of pilot study</td>
<td>Publication of guidance and subsequent consideration of feedback</td>
<td>Quarter 1 2018</td>
<td>Quarter 3 2019</td>
<td>None</td>
<td>PB</td>
<td></td>
<td>Analysis of the pilot findings has been slightly delayed. On track to meet deadlines for provision to Education Committee in May.</td>
</tr>
<tr>
<td>Review of registrations processes to check compliance with legal requirements, good practice and efficiency, and report on recommended actions</td>
<td>Report to Council on any significant changes recommended to be made to the registrations processes</td>
<td>Quarter 1 2018</td>
<td>Quarter 2 2018</td>
<td>May have implications for GDPR review and IT strategic review. Important to complete by end Quarter 2 in order to tie in with workload pressures for registrations team</td>
<td>CER and PB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development of further guidance about how we reach registrations decisions (e.g. in relation to English language).</td>
<td>Report to Council once guidance drafted. Guidance to be published on the website once finalised, and its publication highlighted to registrants, professional associations (and applicants for registration).</td>
<td>Quarter 1</td>
<td>Quarter 2</td>
<td>Additional areas for development of guidance likely to emerge from review of registrations processes</td>
<td>CER and PB</td>
<td></td>
<td>No project plan required at this stage. To be initiated once review project further progressed.</td>
</tr>
<tr>
<td>Assessment of 2 new UK chiropractic education programmes (AECC and LSBU)</td>
<td>Education Committee advises Council on whether/not to recognise each programme</td>
<td>Already underway submissions received in 2017</td>
<td>Quarter 3 2018</td>
<td>none</td>
<td>PB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revision of guidance for education providers and students concerning</td>
<td>Publication of guidance and consideration by the Education Committee of feedback</td>
<td>Already initiated and progressing</td>
<td>Quarter 4 2018</td>
<td>none</td>
<td>PB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issue</td>
<td>Progress</td>
<td>Action</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>student fitness to practise and student health and disability</td>
<td>received about its impact on providers/students.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upgrade to Registrations database, to support registrants’ use of online services</td>
<td>Report to Council on successful completion of work, and communication about it to the profession. Any feedback received from registrants to be reported to Council later in 2018.</td>
<td>Quarter 1 2018 Quarter 1 2018 IT Strategic review PG Amber RAG rating as no project plan in place. PG has met with the database provider and our outsourced IT supplier, following a quote for an upgrade path. A new database server has been delivered and will be commissioned in Quarter 1. The transfer of data and upgrading of Oracle forms will happen in April and the system is expected to go live in May 2018.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation of external advice on FTP processes already received including:</td>
<td>Investigating Committee members and others to be consulted about key aspects of draft Guidance. Investigating Committee Guidance document to be considered by Council prior to finalisation. Report to Council on completion of revision to manual and any significant changes made.</td>
<td>Quarter 1 2018 Quarter 3 2018 Impact on ongoing investigations will need to be carefully considered. Amendment to policies agreed by Council in 2015 around investigation of allegations may be required, in light of the external advice received. RH PG Amber RAG rating as no project plan in place. Slight delay in RH sharing draft Investigating Committee Guidance document with Committee members following two unexpected developments: • a suggestion made at the Committee training day in February that specific guidance on investigating ill-health should be developed; • a query raised on the referral threshold which necessitated obtaining advice. Council is to consider next steps on the draft IC guidance at its private</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Maintenance/improvement of performance against investigations KPI

<table>
<thead>
<tr>
<th>Session</th>
<th>Performance against the KPI is reported to Council each quarter as part of the performance report.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>Quarter 3</td>
</tr>
</tbody>
</table>

Work not yet commenced on FTP team manual – to start in Quarter 2.

No project plan required as this falls within the remit of the Audit Committee to monitor.

Progress reported in the quarterly Performance Reports to Council.

Revision of Disclosure Policy (to take account of GDPR)

<table>
<thead>
<tr>
<th>Session</th>
<th>Report to Council on changes recommended to the current Policy. Publication of revised Policy on the website.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1 2018</td>
<td>Quarter 2 2018 (end)</td>
</tr>
</tbody>
</table>

Amber RAG rating as no project plan in place.

PG to meet with external solicitors on 16 March to plan for this work and review of the data retention policy.

Review of all processes to establish GDPR compliance

<table>
<thead>
<tr>
<th>Session</th>
<th>Report to Council on recommendations for changes to processes, timescale for implementation, and anticipated impact.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1 2018</td>
<td>Quarter 2 2018 (end)</td>
</tr>
</tbody>
</table>

Amber RAG rating as no project plan in place and limited time to ensure compliance with statutory timeframe.

An audit of current data protection arrangements took place in December 2017 – the report is awaited.

PG has undertaken an initial information audit in relation to Finance and FTP functions. PG is considering revised policies for the information governance framework.

A new server is planned for delivery in April/going live in May.
<table>
<thead>
<tr>
<th>Project Description</th>
<th>Timeline</th>
<th>Action Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment of overall</td>
<td>Quarter 1 2018/Quarter 2 2018</td>
<td>Appointment recommendation to be made to Council by Quarter 2 2018. Reporting to Council on progression of cases to conclusion at PCC hearings. Recruitment of additional registrant members for PCC, appointment of additional PCC panel chairs, and co-option of additional PCC lay members. Implementation of appraisal/development processes for PCC and HC members.</td>
</tr>
<tr>
<td>Chair of PCC and HC</td>
<td></td>
<td>CER</td>
</tr>
<tr>
<td>Publication of revised Indicative Sanctions Guidance for PCC and HC</td>
<td>Ongoing/Quarter 3</td>
<td>Council to consider document at end of (current) public consultation, prior to finalisation. Finalised Guidance to be published on the website and communicated to all relevant stakeholders.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CER</td>
</tr>
<tr>
<td>Planning effectively for the office move</td>
<td>Quarter 1 2018/Quarter 2 2018</td>
<td>Activities reported to Council quarterly. Significant developments reported to Chair of Council in the interim. <strong>Amber RAG status as project plan not yet finalised (a draft plan is being discussed across the SMT and should be finalised before the Council meeting). Negotiations with HCPC completed by RH. Extension of lease of current premises granted until 12 October.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ALL SMT</td>
</tr>
<tr>
<td>Activity</td>
<td>Initial Action</td>
<td>Progress</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Tender for provision of external legal services</td>
<td>Initial advice as to format of tender process to be obtained.</td>
<td>Quarter 1</td>
</tr>
<tr>
<td></td>
<td>Progress on finalisation of tender process and timeframes to be reported to Council.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outcome of tender to be reported to Council.</td>
<td></td>
</tr>
<tr>
<td>Review potential for cost savings in areas other than in relation to external legal services</td>
<td>Report to Council on any areas where potential cost savings are identified.</td>
<td>Quarter 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Embedding shared values and behaviours across the staff team</td>
<td>Activities and expected outcomes from it to be reported to Council.</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Competency framework to be developed will be essential for modernised job descriptions.</td>
<td></td>
</tr>
<tr>
<td>Preparation of Annual Report and Accounts</td>
<td>Reported to the Audit Committee and to Council</td>
<td>Quarter 1</td>
</tr>
<tr>
<td>Event Description</td>
<td>Details</td>
<td>Timeline</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------</td>
<td>----------</td>
</tr>
<tr>
<td>Reporting on performance to the PSA</td>
<td>The Executive report to Council at each meeting will contain updates as to progress of the PSA performance review once the annual cycle begins. Audit Committee considers any action to be taken in respect of failure to meet any of the Standards of Good Regulation, as reported on by the PSA.</td>
<td>Quarter 1 2018, Quarter 2 2018, n/a</td>
</tr>
<tr>
<td>Activity to be initiated in Quarter 2 (RAG rating not included unless, exceptionally, the work actually commenced in Quarter 1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finalising a strategy about the GCC’s role in “developing” the profession</td>
<td>Council working group to take forwards development of the strategy. Strategy to be published and communicated to the profession and key interest groups.</td>
<td>Quarter 2 2018, Quarter 4 2018</td>
</tr>
<tr>
<td>Progression of advertising caseload to Investigating Committee – increase to number of Committee meetings to accommodate increased workload:</td>
<td>Majority of cases to be concluded by the Investigating Committee during 2018. Progress reported to Council as part of Executive Report each quarter.</td>
<td>Quarter 2 2018, Quarter 4 2018/Quarter 1 2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeline</th>
<th>Responsible Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>No project plan required. Start of performance review cycle reported in Executive Report.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PG has developed initial project plans with the FTP team – currently subject to fluctuation. The proposal is to progress batches of 50 cases at a time. This should mean that the majority of cases will have been considered by the IC by the end of 2018. A finalised project plan will need to be developed by the start of Quarter 2.</td>
<td></td>
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</tr>
<tr>
<td>Area</td>
<td>Activity</td>
<td>Quarter 2 2018</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Redevelopment of senior FTP team lead role</strong> – including effective management of external legal suppliers and provision of legal advice internally across all functions.</td>
<td>Report to Council once job description finalised to seek authorisation for initiation of recruitment process in Quarter 3.</td>
<td></td>
</tr>
<tr>
<td><strong>Recruitment</strong></td>
<td>Audit reports are provided to the Audit Committee.</td>
<td>Quarter 2</td>
</tr>
<tr>
<td><strong>Focused FTP audits</strong></td>
<td>Audit Committee considers any recommendations made and seeks appropriate assurances from the Executive.</td>
<td></td>
</tr>
<tr>
<td><strong>Reappointment process for 1 registrant Council member</strong></td>
<td>Process approved by Council prior to initiation. Process scrutinised by PSA before Privy Council consider making the reappointment. Outcome reported to Council</td>
<td>Quarter 2 2018</td>
</tr>
<tr>
<td><strong>Appointment process for 1 registrant Council member vacancy</strong></td>
<td>Process approved by Council prior to initiation. Process scrutinised by PSA before Privy Council consider making the appointment. Outcome reported to Council</td>
<td>Quarter 2 2018</td>
</tr>
<tr>
<td><strong>Periodic review and updating of Governance Manual</strong></td>
<td>Progress reported to Audit Committee and/or Council at each meeting. Any significant changes to be approved by Council. Publication of a revised</td>
<td>Quarter 2 2018</td>
</tr>
</tbody>
</table>

Privy Council has confirmed the GCC can run with one or more vacancies, so this project is no longer required during 2018.

Project plan developed and progressed during Quarter 1, at the Chair’s request. The project should be completed before the end of Quarter 3 i.e. in time for a
<table>
<thead>
<tr>
<th>Task</th>
<th>Deliverable</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning for implementation of previously developed PCC and HC appraisal/development processes, involving overall Chair of PCC and HC</td>
<td>Report to Council by Quarter 4 2018 on outcome of planning process.</td>
<td>Quarter 2 2018</td>
<td>Quarter 4 2018</td>
<td>See above</td>
<td>PG</td>
<td></td>
</tr>
<tr>
<td>Implementation of redeveloped appraisal/development processes – additional fees for Chair’s time and expenses</td>
<td>Report to Council on progress in implementation at end of 2018</td>
<td>Quarter 4 2018</td>
<td>Ongoing</td>
<td>See above</td>
<td>PG</td>
<td></td>
</tr>
<tr>
<td>Appointment of additional registrant PCC members</td>
<td>Recommendation of candidates to Council, following recruitment process (managed in-house).</td>
<td>Quarter 2 2018</td>
<td>Quarter 3 2018</td>
<td>Failure to do this would impact on ability to maintain progress of PCC hearings. PCC Chair appointment must be made first.</td>
<td>PG</td>
<td></td>
</tr>
<tr>
<td>Co-option of additional lay PCC members (e.g. from adjudicating panels at other regulators in the sector)</td>
<td>Proposal for co-opting additional lay members to be considered by Council Quarter 2. If proposal is approved, recommendation of candidates to be made to Council in Quarter 2/Quarter 3.</td>
<td>Quarter 2 2018</td>
<td>Quarter 2/3 2018</td>
<td>If current lay members successfully apply to also be eligible to sit as chairs, that would diminish the lay pool – see below. PCC Chair appointment must be made first.</td>
<td>PG</td>
<td></td>
</tr>
<tr>
<td>Appointment of additional PCC panel chairs from the current pool of lay PCC panellists (provided that Council agrees to remove the requirement for PCC panel chairs to be legally qualified)</td>
<td>Proposal to be considered by Council (Quarter 1/Quarter 2). If approved, recommendation of candidates to be made to Council by Quarter 3.</td>
<td>Quarter 2 2018</td>
<td>Quarter 3 2018</td>
<td>We anticipate some current lay PCC members applying to become panel chairs, if Council lifts the requirement for legal qualification.</td>
<td>CER and PG</td>
<td></td>
</tr>
</tbody>
</table>
qualified, put in place in June 2014 on the erroneous basis that it would remove the requirement for a Legal Assessor to be present at PCC hearings)

| Work to strengthen capacity and capability of staff team – including review of job descriptions and staffing structure, alongside review of key policies e.g. rewards and remuneration | Council to receive reports at each meeting on the progress and outcomes of the work to review job descriptions and staffing structure once initiated. Remuneration Committee to consider key policies on reward and remuneration. | Quarter 2 2018 | Quarter 4 2018 | Implementation of any changes recommended from reviews in key functional areas | CER |
To: The Council, General Chiropractic Council
From: Jamie Button
Subject: Introducing administrative fees for producing Certificates of Current Professional Status
Date: 21 March 2018

Purpose
1. The purpose of this paper is to ask Council to consider whether an administration fee should be introduced for production of Certificates of Current Professional Status (CCPS).

Background
2. Where a registrant applies to another regulator, either in the UK or overseas, a document is required as evidence of the chiropractor’s standing with the GCC.
3. The document provided direct to another regulator is known as a Certificate of Current Professional Status, as set out in Agreement 1 of the 2005 Edinburgh Agreement, and includes basic registration details, as well as information on the registrant’s current standing and any disciplinary history.
4. The GCC itself requires such certificates on application for initial registration, restoration and transfer to practising registration for the same reason.
5. The cost of producing the certificate is not covered within any current fees and often requested by those no longer registered with the GCC. The GCC receives requests for between 40 and 50 certificates per annum.
6. Production of a CCPS involves the time of several staff members and the cost will vary in each case depending on whether prior disciplinary matters have been found against the applicant. In addition there are also costs for stationery and postage.

What other regulators do
7. Of the UK regulators three charge for providing CCPS’s as follows:

<table>
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<tr>
<th>Regulator</th>
<th>Fee for CCPS</th>
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<tr>
<td>General Optical Council</td>
<td>£15</td>
</tr>
<tr>
<td>Nursing and Midwifery Council</td>
<td>£34</td>
</tr>
<tr>
<td>General Pharmaceutical Council</td>
<td>£81</td>
</tr>
</tbody>
</table>
8. In addition, overseas regulators, such as the Australian Health Professions Regulation Authority, New Zealand Chiropractic Board and Board of Chiropractic Examiners California all charge for provision of documentation evidencing the standing of the registrant.

The proposal

9. Given the work required as stated in 6 above, it is suggested that an administrative fee of £50 is levied for processing Certificates of Current Professional Status to ensure associated costs are recovered.

Financial implications

10. Implementation of a fee will have a positive financial impact, allowing the GCC to recoup costs associated with the administration of producing the certificate.

Legal or Risk implications

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

Equality implications

12. There are no equality implications arising from this paper.

Communications implications

13. Should Council agree with the proposal, the profession will be notified as soon as possible via email with a note in the next newsletter. There will also need to be some amendments to the GCC’s webpages covering CCPS’s.

Action required

14. Council are asked to consider the above proposal.
To: The General Chiropractic Council
From: Chief Executive & Registrar
Subject: Revised Indicative Sanctions Guidance for the Professional Conduct Committee and the Health Committee
Date: 21 March 2018

Purpose
1. Council is asked to consider and to approve for publication the revised version of the Indicative Sanctions Guidance and a bank of template conditions for use by the Professional Conduct Committee (and Health Committee) at Appendix B with effect from 1 May 2018.

Background
2. As previously reported to the Council in previous Executive Reports, the GCC initiated a public consultation exercise in respect of a revised version of the Indicative Sanctions Guidance (ISG) in December 2017. At the same time, the GCC sought comments on a draft bank of template conditions to be used by the Professional Conduct Committee (PCC) and Health Committee (HC).

3. The initiation of the consultation was directly communicated to the professional associations and to those solicitors/Counsel who frequently represent chiropractors at PCC hearings.

4. The consultation commenced on 19 December 2017 and ran for three months until 9 March 2018.

5. Six responses were received to the consultation. Five out of the six responses to the consultation addressed the consultation questions and were generally supportive of the contents of the revised ISG and of the introduction of a bank of template conditions for use by the PCC and HC. The other respondent provided comments without answering the specific consultation questions.

6. Several respondents also provided comments about ways in which aspects of the ISG could be further clarified or strengthened. As a result of the comments, a number of further revisions have been proposed. Appendix A provides information about whether each comment has resulted in amendment being proposed. Part 1 of Appendix A contains a summary of each comment received from four respondents (including the PSA) and the GCC’s recommendation in response to each comment. Part 2 of Appendix A contains the full text of the comments received from one other respondent, along with the GCC’s response.

7. Appendix B contains the updated text of the draft ISG and bank of conditions documents, taking account of the comments received, as set out in Appendix A. In addition, a provision has been inserted setting out how the guidance will apply in respect of any hearings that adjourned part-heard and will resume after the revised guidance comes into force.
Equality and diversity implications
8. None have been identified.

Financial implications
9. There are limited resource implications arising from the publication of the revised guidance. The guidance will be published on the GCC’s website, which will involve a minimal amount of staff time in amending the relevant website page.

10. Training about the changes made to the ISG and about the bank of conditions will be provided to the PCC at a forthcoming scheduled annual training day on 26 March 2018.

Legal or Risk Implications
11. The only legal or risk implications that might arise from publication of the guidance would be in circumstances where it was unclear to a participant in the PCC or HC process whether the previous version of the ISG or this revised version was applicable.

12. This risk will be mitigated by including a clear statement on the front of the document and in the introduction section about the date from which it is to be applied. A clear statement will also be made about this on the GCC’s website when the documents are published there.

Communications implications
13. Once the revised GCC guidance is approved by Council for publication, we intend to include an item about it in the next GCC newsletter. The PCC members will be informed at a scheduled training day on 26 March 2018. A written communication will also be sent to PCC members, to any Legal Assessors who frequently sit with the PCC/HC and to those Counsel/solicitors who regularly represent registrants at hearings before the revised ISG and bank of conditions come into effect.

Action
14. Council is asked to consider the revised version of the ISG and the template bank of conditions at Appendix B and approve them for publication, having first considered the action the GCC has taken in response to comments received on the documents as detailed in Appendix A.
Appendix A – Part 1

1. Introduction

Part 1 of Appendix A summarises comments received from four respondents to the consultation. Details of the comments received from one further individual are set out in Part 2 of Appendix A. The other respondent did not provide any comments over and above answering the consultation questions. The complete consultation responses can be provided on request to Council members.

The GCC’s recommendation in response to each comment is set out below in blue font underneath each comment.

2. Comments and GCC responses

**Summary of comment:** Clarification needed of potential inconsistency in paragraphs 16 -18 of references to “sequential approach” and to decisions being “taken together” in order to more clearly demonstrate that panels should take a sequential approach to considering a sanction.

GCC response: Additional wording has been inserted into paragraph 18 to state “Decision-making about sanction takes place only once the PCC has decided that the allegation is well-founded”. The explanation about the standard required of a chiropractor and the impact of a breach of the GCC Code has been moved into a new paragraph, to aid clarity.

**Summary of comment:** There is case-law to the effect that there is nothing wrong in principle with the regulator making a submission about sanction to the panel. PSA is supportive of regulators giving an indication of recommended sanction.

GCC response: the wording of the ISG does not require amendment as it already states that the GCC “may make submissions about the appropriate sanction”.

**Summary of comment:** Paragraphs 27 and 48 of the ISG could more clearly direct panels to consider a more restrictive sanction and to provide reasons about why that sanction is not proportionate.

GCC response: Paragraph 27 of the ISG already requires the panel to judge whether a sanction will be sufficient “and if it will not, moving on to consider the next least restrictive sanction”. It also states “It is good practice for the committee to provide reasons for its conclusions about each sanction option considered.” No amendment to paragraph 27 is required.

Paragraph 48 of the ISG has been amended to refer to the written determination including an explanation of whether the panel considered a more restrictive sanction option and if so, the reasons why that more restrictive option was considered unnecessary. The additional wording says: “The written determination must set out whether the committee considered imposing a more restrictive sanction and provide reasons for any conclusion that a more restrictive sanction was unnecessary”.

37
Summary of comment: The list of mitigating factors could usefully highlight the case-law that the absence of an aggravating factor should not be treated as a mitigating factor.

GCC response: A new paragraph has been inserted at the end of the section on mitigating factors stating that “Committees will be mindful that the absence of what would otherwise be an aggravating factor is not to be treated as a mitigating factor”.1

Summary of comment: The ISG could be clearer about the fact that personal mitigation testimonials are only relevant at the sanction stage whereas other testimonial evidence may be relevant at earlier stages of the hearing.

GCC response: Paragraph 39 has been amended to note that testimonial evidence concerning the registrant’s propensity to commit the acts complained of may have been admitted at the pre-sanction stage of the hearing, and that personal mitigation testimonials are only relevant at the sanction stage. The additional wording replaces the first sentence with “Testimonial evidence concerning the chiropractor’s propensity to commit the acts alleged may have been presented at the fact-finding stage of the hearing. At the stage when the committee considers sanction, personal mitigation testimonials may also be presented, for example concerning the chiropractor’s standing in the community or the profession.”

Summary of comment: The ISG could also refer to the GCC’s guidance on candour and its signature of the joint regulatory statement about the professional duty of candour.

GCC response: Paragraph 42 of the guidance has been expanded to refer to the GCC guidance on candour and the joint regulatory statement on candour. Additional wording inserted at the end of paragraph 42 says “The GCC has published guidance about the duty of candour to assist chiropractors in applying the Code’s requirements, which sets out the steps that must be taken before starting care and after something has gone wrong.”2

Add in paragraph 17(b) “whether taken individually or collectively” after “some or all of these”.

GCC response: Amendment made.

“You have too many cases going through, start by mediation and filter out the trivia, do not process other regulators’ responsibilities and cut the waste on experts’ witnesses”

GCC response: This comment is not relevant to the ISG or bank of conditions, it is about the GCC’s FTP process more generally. There is therefore no amendment to the ISG to be considered.

Summary of comment: Lack of clarity about whether the PCC can issue a suspension at a hearing to review conditions.

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1 PSA v NMC and Judge EWHC 817 (Admin)
2 [https://www.gcc-uk.org/good-practice/guidance/](https://www.gcc-uk.org/good-practice/guidance/)

The GCC is also a signatory to the joint statement made by the regulators of healthcare professionals on the professional duty of candour, available from: [http://www.gcc-uk.org/UserFiles/Docs/Joint%20statement%20on%20the%20professional%20duty%20of%20candour%20FINAL.pdf](http://www.gcc-uk.org/UserFiles/Docs/Joint%20statement%20on%20the%20professional%20duty%20of%20candour%20FINAL.pdf)
GCC response: The PCC's powers are set out in the Act – there is no provision for replacement of conditions with suspension by the PCC. No amendment to the ISG is required.

Summary of comment: Use of “serious” is unnecessary in paragraph A1 as a finding of impairment is conclusive.

GCC response: The statutory wording in relation to allegations of ill-health requires the impairment to be “serious”. No amendment to the ISG is appropriate.

Summary of comment: Conditions C5 and C5 should limit the requirement to disclose to patients the fact that a workplace supervisor/auditor is in place to current patients only.

GCC response: The relevant conditions will be amended to make it clear that disclosure is only required to current patients while the conditions are in force.

Summary of comment: It may be useful to include a condition allowing for the appointment of a workplace mentor (rather than a supervisor) in relation to proved UPC that relates to behaviour/conduct rather than clinical failings.

GCC response: Conditions are not often imposed by GCC panels. In any healthcare regulator, conditions are more usually imposed in cases involving clinical concerns than in cases involving conduct/behavioural issues.

On balance, as any panel has the power to put in place a condition not contained within the bank of conditions, we consider it unnecessary to include a condition about the appointment of a workplace mentor at the current time. This can be kept under review and reconsidered in the event of any cases occurring where such a condition is identified as being required.

Summary of comment: recommendation that the GCC publishes a glossary of terms alongside the ISG.

GCC response: It appears to us that the key terms used within the ISG are already explained in the Act, the statutory rules or the case-law.

No examples of terms that required explanation were provided alongside the comment.

We have not previously received any requests for a glossary in relation to the terms used in the current ISG.

We do not propose to compile a glossary at the current time but will keep this suggestion under review.
1. Introduction

One respondent to the consultation did not answer the consultation questions but instead provided the comments set out below.

The GCC’s response to these comments is set out in blue font.

2. The respondent’s comments

Indicative Sanctions Guidance for Consultation Document

At Para 18: ‘The Standard required of a registered chiropractor is set out in the Code.’

An ‘s’ on the end of standard to make standards would fundamentally alter the meaning of the sentence. The Code is a guide for the expected conduct of a Chiropractor and it contains standards.

GCC response: the reference in paragraph 18 is to “the standard” as a general concept not to the specifics of individual standards. No amendment made

The Medical Standard

Chiropractic is a medical profession. The standard for a Chiropractor to meet depends upon the context of the situation. A general Bolam Standard exists in most instances but not all for example Montgomery decision in the context of consent.

Professional Incompetence

Common Law Plugs the Gap

In consideration of professional incompetence, as the Chiropractors Act does not give explicit guidance, English common law could plug the gap. A framework for incompetence should be provided for in the indicative sanctions documents, as a guide for the PCC committee.

Consent

The GCC should be bold enough to utilise the common law as an authority to include in professional incompetence matters of consent.

Incompetent Behaviour

There ought to be consideration of undue influence and necessity as confirmed in the written record and included in a professional incompetence framework e.g. is the behaviour/intervention that of a reasonable body of chiropractors. Where it might be found that a respected and reasonable body of chiropractors would not have behaved in the same way or intervened in the same manner one would hope for the honest mistake doer that a process of insight would exist. Reflexive thought and unmet patient needs / chiropractor’s educational needs might be utilised in helping the mistake doer to learn from and not just be punished nor blamed.

Human Rights
Incompetence should also include Convention Rights such as The European Convention of Human Rights, The Rights of the Child and the Committee on the Rights of Persons with Disability.

Data

Incompetence should also include mishandling of Data.

Organisational Duty

The GCC ought to consider an organisational duty in the light of keeping up with statutory obligations eg providing regular training and holding clear policy documents about the use and operation of x-ray equipment. There would also be an organisational duty with regard to the positive Duty of Candour and an organisational Duty to register with an independent supervisory body such as the Care Quality Commission for governance policies and x-ray protocols / working practises. Organisational Duties where considered to have mitigated the chiropractors conduct or competence would uphold the public interest at the source, whilst being consistent with a non-punitive approach to regulation of the chiropractic profession.

GCC response: The comments above relate to how matters such as unacceptable professional conduct and professional incompetence are to be decided. These matters are not necessary or appropriate to include within a guidance document that is focused on how panels approach decisions about sanction, once their decisions about UPC/professional incompetence have already been reached. Some of the comments appear to reflect an incomplete understanding of the law.

Conditions for Sanctions Document

Workplace Supervision is a logistical and fiscal enigma for chiropractors and especially sole practitioners because of the way they are paid. Particular training should enable chiropractors with an interest in rehabilitation of colleagues to full competence be found on an official list of potential supervisors or trainers. A fee structure for the trainer’s time can be established for any chiropractor needing supervision that is fair and reasonable and not just reflective of a supervisory chiropractor’s clinical potential income during that time. Placing an undue financial burden on a chiropractor wishing to rehabilitate after a sanction of supervised practise has been made upon them. The motivation to become a supervisory chiropractor should not be purely financial.

GCC response: These suggestions about how a structure could be created to identify supervisors are not for inclusion within the bank of template conditions.

Any panel imposing a condition will need to check that it is workable – which includes the chiropractor being able to pay the relevant fee.

It is not currently considered necessary for the GCC to invest resources in developing a bank of “approved” supervisors (or assessors) and a structure around their involvement, given the relatively few occasions on which conditions are likely to be imposed. This suggestion can be kept under review.

Any Personal Development Plan sanction should be in addition to a chiropractors CPD for the year.
GCC response: It is for the panel to decide whether a particular PDP is adequate for the purpose. There is no obvious reason why a chiropractor should not be able to list as part of their subsequent CPD the work they have undertaken as the result of compliance with a Conditions of Practice Order. Sanctions are not imposed for the purpose of punishment.

**Audit sanction** should also be incorporated into a chiropractor’s educational needs and a PGCert in clinical development be completed within 3 years at a recognised institution. Encouraging Chiropractors to continually improve through governance. Providing greater protection for the public in the future.

GCC response: The task for the panel at a hearing is to put measures in place that assure the panel that the chiropractor remediates their failing so that they are “fit to practise” before they are allowed to return to unrestricted registration. It is not part of the panel’s role to put conditions in place for the future after the chiropractor has satisfied the panel that their registration restriction can be lifted.

GCC appointed Assessor should have clear pricing structure that is reasonable to the assessor and not incapacitating for the chiropractor sanctioned against. A means tested process would be fair and facilitate the motivation of the assessor to not just be financial.

GCC response: see earlier response on a similar comment about how supervisors could be put in place.

**Health Issues**

The sanctions against a chiropractor in the Health Issues section are based around a medical model of health. In addition any other model of health should be made available to the chiropractor with health concerns. Respecting the Chiropractors intact capacity despite ill health and their personal autonomy at planning their own health plan. The health plan must be overseen by two professionals in the relevant area of healthcare.

GCC response: the statutory remit for the panel is to determine whether the chiropractor’s fitness to practise is seriously impaired as a result of physical or mental health, as required in the legal framework, and if so, to impose an appropriate sanction (which could include conditions). In order to ensure that it fulfils its over-arching objective of protecting the public, the GCC intends to follow the same approach as the other healthcare regulators in this area, in terms of the “medical model” of health.

Any sanction related fees a chiropractor may become liable for should be laid out and accessible as a published document by the GCC.

GCC response: This suggestion is about logistical arrangements rather than about the bank of template conditions itself. See earlier comment.

A reflective piece of writing / learning diary should be written in a way that can benefit learning from others. EG learning diaries are anonymised and the principles made public to the Chiropractic profession to foster a learning culture.
GCC response: The purpose of a condition requiring reflective learning is specifically about that chiropractor’s remediation/insight, not to benefit other registrants. It would not be appropriate to amend the condition to reflect the purpose suggested.

The GCC will take account of this comment in planning its sharing of learning from PCC cases across the profession.

Any Chiropractor who experiences the committee process should provide feedback about their service. Chiropractors sanctioned against should be able to ask for a review of their case and the process of which should be made available to each chiropractor experiencing a committee process. The most obvious review would be with the Privy Council, however this may be prohibitively expensive and thus serve a miscarriage of justice. Routes for review ought to be made accessible.

GCC response: This comment is not relevant to the wording of the ISG or the bank of conditions. The GCC has for several years operated a process enabling chiropractors and others to provide feedback about their experiences of the FTP process. There is also a separate “complaints” process by which issues around the GCC’s handling of its processes can be raised.

The means by which PCC outcomes can be reviewed is by way of an appeal to the High Court – to provide the additional type of appeal mechanism suggested would require changes to be made by Parliament to the statutory framework.
Section A: Introduction

A1. The role and status of the sanctions guidance

1. This guidance has been developed by the GCC for use by the Professional Conduct Committee ("the PCC") when it is considering what sanction to impose upon a chiropractor following a finding of unacceptable professional conduct, professional incompetence or a criminal conviction, and by the Health Committee (HC) following a finding that a chiropractor’s fitness to practise chiropractic is seriously impaired as a result of physical or mental condition. It is also to be used where a committee is reviewing a previously imposed order. It outlines the decision-making process and the factors to be considered.¹

2. Committee members must use their own judgement when making decisions as they are acting in a judicial capacity, but within a framework set by the GCC. This guidance provides the framework and committee members are expected to take full account of it. Where a committee has reason to depart from it, it should clearly explain why in its written determination. Nothing in this guidance is intended to restrict a committee’s discretion in any particular case.

3. The sanctions guidance is an important link between two of the GCC’s regulatory roles: setting standards of conduct and practice for the profession and dealing with complaints against chiropractors. The Council of the GCC is responsible for all decisions taken by the PCC and the HC, although Council members do not sit on either committee. The chiropractic and lay members appointed by the Council to sit on the PCC and HC must use their own judgement in deciding whether allegations against chiropractors are well-founded. These independent decisions must take account of the requirements of The Code: Standards of conduct, performance and ethics for chiropractors, effective from 30 June 2016³ ("the Code") and any other guidance the Council issues to the profession.

4. The sanctions guidance aims to promote consistency and openness in decision-making. It ensures that all parties are aware from the outset of the approach to be taken to sanctions by the PCC or HC. The use of guidance on sanctions has in similar contexts received strong endorsement from the judiciary, and Mr Justice Collins in the case of CRHP -v- (1) GMC (2) Leeper [2004] EWHC 1850 recorded that:

"It helps to achieve a consistent approach to the imposition of penalties where serious professional misconduct is established. The [panel] must have regard to it although obviously each case will depend on its own facts and guidance is what it says and must not be regarded as laying down a rigid tariff."

5. Mr Justice Newman, in the case of R (on the application of Abrahaem) v GMC [2004] described the GMC’s Indicative Sanctions Guidance as:

"Very useful guidelines and they form a framework which enables any tribunal, including this court, to focus its attention on the relevant issues. But one has to come back to the essential exercise which the law now requires in what lies behind the purpose of sanctions, which, as I have already pointed out, is not to be punitive but to protect the public interest; public interest is a label which gives rise to separate areas of consideration.

¹ Any list of factors referenced in this guidance should be considered as a non-exhaustive list. Committees should use their discretion when imposing sanctions, and can consider other factors as they consider necessary and proportionate.
² The Council makes appointments based on recommendations made to it by an arms-length panel.
³ The Code replaced the Code of Practice and Standard of Proficiency 2010, which in turn replaced the Code of Practice and Standard of Proficiency 2005. Committees must refer to the code that was in place at the time of the alleged conduct.
Appendix B: Indicative Sanctions Guidance

6. This revision of the guidance comes into effect and will be applied from [1 May 2018]. In any case where a committee, had, prior to [1 May 2018], determined that an allegation was well-founded and had heard any submissions about sanction by the parties but had then adjourned the hearing before determining sanction, that committee shall continue to apply the indicative sanctions guidance that was in force at the date it adjourned the hearing. In all other cases, this revised guidance shall be applied.

6.7. It is intended that this sanctions guidance is a 'live document' with users having the opportunity to provide comments on its use to the GCC. This will allow changes to be considered on a regular basis. If, having used this guidance, you have some comments to make, please email them to isg@gcc-uk.org with 'Comments on the sanctions guidance" in the subject line.

A2. The GCC’s over-arching objective

7.8. The GCC is the statutory regulator of the chiropractic profession in the UK. Its functions are set out in the Chiropractors Act 1994 (“the Act”).

8.9. The Health and Social Care (Safety and Quality) Act 2015 introduced the same over-arching objective for all of the statutory regulators of health and care professionals in the UK. That over-arching objective is the protection of the public. The 2015 Act states that the pursuit of protection of the public involves the pursuit of the following:

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

A3. Equality & diversity statement

9.10. The GCC is listed in the Equality Act 2010 as a public authority and so must have due regard to the need to:

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

10.11. The public sector equality duty applies to the GCC in relation to the exercise of its public functions.4

A4. Why are sanctions imposed?

11.12. The main reason for imposing sanctions is to protect the public, which is the GCC’s statutory over-arching objective.5

12.13. The over-arching objective codifies the position previously established in case law - that protection of the public is a broad term and includes all three of the limbs set out above in

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4 The GCC’s published equality scheme can be found on the website – see https://www.gcc-uk.org/about-us/equality-and-diversity/
5 Section 4A Chiropractors Act 1994 (inserted by the Health and Social Care (Safety and Quality) Act 2015
paragraph 89. Each reference to protecting the public in this guidance should be read as including all three limbs of the over-arching objective. There may be a public interest in allowing a chiropractor's return to safe practice, and, where appropriate, committee decisions should take account of this. However, committees should bear in mind that their first concern is the protection of the public in the broad sense set out.

13.14 The purpose of sanctions is not to punish, but sanctions may have a punitive effect. 6

A5. The committee decision-making process

Nature of allegations

14.15 Section 20(1) of the Act sets out four types of allegation:

1. the chiropractor has been guilty of conduct which falls short of the standard required of a registered chiropractor (defined as "unacceptable professional conduct" ("UPC") in section 20(2));
2. the chiropractor has been guilty of professional incompetence;
3. the chiropractor has been convicted (at any time) in the United Kingdom of a criminal offence;
4. the chiropractor's ability to practise as a chiropractor is seriously impaired because of their physical or mental condition.

15.16 Where the Investigating Committee considers one of these allegations and finds that there is a case to answer, it will refer an allegation concerning health to the HC, and an allegation of any other kind to the PCC. 7

The staged approach

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

17.18 In the case of an allegation concerning either UPC or professional incompetence, the PCC has to decide in this order:

a) whether the facts as set out in the allegation have been proved by the GCC according to the "balance of probabilities". If none of the facts have been proved, the allegation is not well-founded;

b) whether, if any of the facts have been found to be proved, some or all of these (whether taken individually or collectively) constitute UPC or professional incompetence, as alleged. If the PCC finds they do not, the allegation is not well-founded;

c) if the allegation is well-founded, which of the sanctions available to the PCC is the minimum necessary to protect the public.

19. The first two decisions are taken together; after the committee has considered all the evidence presented to it and has asked any questions for clarification, Decision-making about sanction takes place only once the PCC has decided that the allegation is well-founded.

18.20 The standard required of a registered chiropractor is set out in the Code. Section 19(4) of the

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6 Raschid v Fatnani v The General Medical Council [2007] 1 WLR 1460
7 Section 20(12) Chiropractors Act 1994
8 The GCC must prove that it is more likely than not that whatever is alleged occurred. It is not for the chiropractor to disprove the allegation.
Chiropractors Act 1994 provides that, where a chiropractor is alleged and found to have breached any provision within the Code, this shall not be taken, of itself, to constitute UPC. However, any breach will be taken into account in any proceedings.9

19.21. In the case of an allegation concerning a conviction, the PCC has to decide in this order:

a) whether the fact of the conviction is proven. The process to be followed by the PCC in such cases is set out in more detail at paragraphs 525-578. If the fact of the conviction is not proven, the allegation is not well-founded. If the fact of the conviction is proven, the matter is well-founded;

b) if the allegation is well-founded, whether the criminal offence has any material relevance to the fitness of the chiropractor to practise chiropractic. If it has no material relevance, the PCC may take no further action;

c) if the criminal offence has material relevance, which of the sanctions available to the PCC is the minimum necessary to protect the public.

20.22. In the case of an allegation concerning impairment of fitness to practise due to a physical or mental condition, the HC should usually approach its decision-making in this order:

a) whether the GCC has proved, on the balance of probabilities, that the chiropractor suffers from the physical or mental condition as alleged. If the HC finds that that is not proved, the allegation is not well-founded;

b) whether, if the GCC has proved that the chiropractor suffers from the physical or mental condition as alleged, the chiropractor’s ability to practise as a chiropractor is seriously impaired as a result. If the HC finds that it is not, the allegation is not well-founded;

c) if the allegation is well-founded, which of the sanctions available to the HC is the minimum necessary to protect the public.

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

The sanction options

22.24. There are four sanctions available to the PCC:

a) Admonishment;

b) Conditions of Practice Order;

c) Suspension Order;

d) Removal from the register.

23.25. There are two sanctions available to the HC if it decides that an allegation against a chiropractor that their ability to practise is seriously impaired because of a physical or mental condition is well founded:

a) Conditions of Practice Order;

b) Suspension Order.

24.26. When considering the appropriate sanction to impose, the committee should consider carefully the matters covered in section B of this document.

9 This is also the approach to be taken in cases of alleged incompetence, though there is no express provision to this effect in the Chiropractors Act 1994
Both the GCC and the chiropractor may make submissions about the appropriate sanction to impose, and the committee should take account of those submissions. In practice the GCC does not generally make the case for a particular sanction to be imposed in its submissions when acting in its prosecuting role, but may draw the committee’s attention to relevant parts of this guidance.

The committee must give reasons in its written determination for the particular sanction that it has decided to impose. The reasons must summarise the committee’s findings on the principal important issues, in order to enable the chiropractor and the public to understand:

a) why a particular sanction has been chosen;

b) how it protects the public;

c) why it is the minimum sanction that is necessary.

A6. Proportionality

In deciding what sanction to impose, the committee must consider the principle of proportionality. This means that when considering what sanction to impose in order to fulfil the statutory over-arching objective, the committee must take into consideration the interests of the chiropractor. The committee should consider the sanctions available, starting with the least restrictive sanction available, judging whether that sanction will be sufficient to achieve the over-arching objective, and if it will not, moving on to consider the next least restrictive sanction. It is good practice for the committee to provide reasons for its conclusions about each sanction option considered.

Once the committee has determined that a particular sanction is necessary to protect the public, that sanction must be imposed, even where that may have a negative impact on the practitioner. This is necessary to fulfil the statutory over-arching objective.

The chiropractor may have been made subject to an interim order suspending their registration during the GCC’s investigation. There is no principle that (as in criminal proceedings if an individual is remanded in custody) time spent suspended under an interim suspension order must be deducted from the length of any suspension then imposed by the PCC or the HC at a hearing. However, the committee should take account of the interim order and its effect on the registrant when deciding whether a sanction is proportionate. Having considered that issue, the committee is entitled to conclude that the interim order does not affect the substantive order.

A7. Mitigating factors

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

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

There are some cases where, regardless of the mitigation presented, a chiropractor’s failings are so serious or persistent that a particular sanction is needed in order to uphold standards and

\[10\] Determinations are subject to review by the Professional Standards Authority for Health and Social Care (PSA), which can refer to court any decision that it considers insufficient to protect the public. Case law has established that the failure by a committee to provide reasons can constitute a ‘serious procedural irregularity’.

\[11\] Professional Standards Authority v (1) GMC & (2) Uppal [2015] EWHC 1304

\[12\] Kamberova v NMC [2016] EWHC 2955 (Admin)

\[13\] Akhtar v GDC [2017] EWHC 1986 (Admin)
maintain public confidence.

33.35. Committees will be mindful that, because they are not concerned with matters of punishment, considerations which would normally weigh in mitigation of punishment are likely to have less effect. For example, see paragraph 346(d) below.14

34.36. The following are examples of mitigating factors:

a) evidence of the extent of the chiropractor’s understanding of and insight into the problem and their attempts to address and remediate it. Such evidence could arise from the facts that have been found proved. It could also take the form of any apologies by the chiropractor to the complainant or person in question. A committee may feel able to give more weight to apologies made at the time or close to relevant events, than to those made at or in the run up to the hearing. Insight could also be evidenced by demonstrable efforts to prevent such behaviour happening again or to correct any deficiencies in performance;

b) evidence of the chiropractor’s overall compliance with important principles of good practice (for example, keeping up to date and working within their area of competence);

c) evidence of mitigating circumstances that contributed to the relevant incidents, for example a lack of training or supervision at work, personal hardship at the time of the relevant events or work-related stress;

d) any hardship which the chiropractor will face as a result of the sanction imposed. Committees will note, though, that the case-law states that while the personal consequences for the chiropractor of a particular sanction being imposed should be taken into account, the essential concern of the committee is to maintain public confidence in the profession even if doing so by imposing a particular sanction entails unfortunate consequences for the individual chiropractor;15

e) while not strictly mitigation, committees will wish to take into account whether or not the chiropractor has previously had a finding made against them by a GCC committee or by any equivalent committee or other regulatory/licensing body.

35.37. In some cases, the stage of the chiropractor’s career may be a mitigating factor - for example because the chiropractor was very inexperienced at the time of relevant events but has subsequently been able to reflect on how they might have done things differently, with the benefit of experience. In other cases, for example those involving predatory behaviour or serious dishonesty, the stage of the chiropractor’s career is unlikely to be regarded as mitigation - serious poor practice or UPC is not regarded as being less unacceptable simply because the chiropractor was inexperienced.

38. The principles in the Code emphasise that chiropractors should take a mature and responsible approach to work. The committee is likely to want to see evidence to support a chiropractor’s submission that they have taken steps to put things right or to prevent similar problems arising in future.

36.39. Committees will be mindful that the absence of what would otherwise be an aggravating factor is not to be treated as a mitigating factor.16

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14 Bolton v Law Society [1994] 1 WLR 512
15 Bolton v Law Society [1994] 1 WLR 512
16 Professional Standards Authority v(1) Nursing and Midwifery Council and (2) Judge [2017] EWHC 817 (Admin)
A8. Aggravating factors

37.40. The committee should consider any aggravating factors presented to it, or which it identifies keeping the over-arching objective in the forefront of its mind.

38.41. Aggravating factors may include (this is not an exhaustive list):

a) previous regulatory findings;
b) abuse of position of trust;
c) lack of insight;
d) direct or indirect patient harm (or conduct which could foreseeably cause harm); and
e) a pattern of UPC over time.

A9. Considering references and testimonials

39.42. Testimonial evidence concerning the chiropractor’s propensity to commit the acts alleged may have been presented at the fact-finding stage of the hearing. At the stage when the committee considers sanction, personal mitigation testimonials may also be presented, for example concerning the chiropractor’s standing in the community or the profession. The chiropractor may present references and testimonials concerning their standing in the community or the profession. The committee should consider the weight to attach to these. The committee should consider who the author of any reference or testimonial is, the nature of their relationship with the chiropractor (for example, if they are a current or former employer), the nature and extent of their experience of the chiropractor when the reference or testimonial was written, how it was solicited, whether the author was aware of the GCC proceedings and the allegations, whether the reference or testimonial appears to be authentic (for example, whether it is signed), and whether the reference or testimonial is relevant to the specific findings made by the committee against the chiropractor. A committee may wish to give more weight to a reference or testimonial if it confirms that the author is willing to attend the proceedings to answer questions.

40.43. The quantity, quality and spread of references and testimonials will vary from case to case and this will not necessarily depend upon the standing of the chiropractor. A committee should not draw adverse conclusions if no references or testimonials are presented. Committees will be mindful that obtaining references and testimonials may be difficult for chiropractors who qualified overseas and have only recently arrived in the UK.

A10. Expressions of regret and apology, and demonstrating insight

41.44. Demonstrating insight is different from expressing remorse. A chiropractor is likely to have demonstrated they have some insight if they: accept they should have behaved differently; take timely steps to remediate; apologise sufficiently in advance of the hearing; and demonstrate the development of insight during the investigation and hearing.

42.45. There is an expectation within the Code that a chiropractor will: think about and learn from events; recognise when things have not gone well; be open and honest and apologise to the patient(s) concerned; and provide redress if appropriate. The Code states that chiropractors must “fulfil the duty of candour by being open and honest with every patient. You must inform the patient if something goes wrong with their care which causes, or has the potential to cause, harm or distress. You must offer an apology, a suitable remedy or support along with an explanation as to what has happened” (Standard B7). It also requires chiropractors to “listen to, be polite and considerate at all times with patients including regarding any complaint that a patient may have”
Appendix B: Indicative Sanctions Guidance

The GCC has published guidance about the duty of candour to assist chiropractors in applying the Code’s requirements, which sets out the steps that must be taken before starting care and after something has gone wrong. 17

43.46. Evidence of the chiropractor’s actions since the relevant events and during the hearing may assist the committee to assess the extent to which any remorse and/or insight has been demonstrated. The committee may wish to have regard to whether the chiropractor has denied the allegation, has been equivocal or ambivalent (perhaps by not acting to improve the position, or by saying they will do so, but then taking no action), has made admissions at the outset of the hearing or late in the day when they think it will then help their case, or has given untruthful evidence to the committee or falsified documents.

44.47. Committees should be aware that different practitioners may express insight and/or remorse in different ways. Cross-cultural communication studies show that there are significant differences in the way that people from different cultures and language groups use language and non-verbal signals both to understand what is being said and to express themselves. This is particularly the case when individuals are using a second language. Awareness of and sensitivity to these issues are important in considering and assessing the degree of insight or remorse shown.

Section B: The sanctions

Bl. Overview

45.48. There is a range of sanction options available to the PCC and HC. Each of these sanctions is addressed individually later in this section, commencing at paragraph 758.

46.49. Rule 19 of The General Chiropractic Council (Professional Conduct Committee) Rules Order of Council 2000 and Rule 19 of The General Chiropractic Council (Health Committee) Rules Order of Council 2000 require the committee to vote on the issue of sanction. No member of the committee can abstain.

47.50. Before the committee moves to a vote it must make sure that it fully discusses the case, any submissions about the appropriate sanction, and is fully aware of all the options available to it. The committee alone makes the final decision on the appropriate sanction, working within the relevant legislation and having regard to the framework set out by this guidance. The committee must keep the statutory over-arching objective in the forefront of its mind at all times.

48.51. The committee’s written determination on the sanction must make it clear that it has considered the available sanctions in ascending order, starting with the least restrictive option, moving upwards if that option was thought to be insufficient, and stopping when it reached the least restrictive sanction necessary to achieve the statutory over-arching objective. The committee’s written determination must provide clear and cogent reasons for imposing a particular sanction, including explaining the relevance of any mitigating and aggravating factors. This is especially important if the sanction is lower, or higher, than that suggested by this guidance or where it differs from the sanction the chiropractor has submitted that the committee should select. The written determination should also include a clear explanation of why a

Available from: https://www.gcc-uk.org/good-practice/guidance/

The GCC is also a signatory to the joint statement made by the regulators of healthcare professionals on the professional duty of candour, available from: http://www.gcc-uk.org/UserFiles/Docs/Joint%20statement%20on%20the%20professional%20duty%20of%20candour%20FINAL.pdf
particular period of sanction has been considered necessary (if the committee selects a sanction that will remain in place for a fixed period). The written determination must set out whether the committee considered imposing a more restrictive sanction and provide reasons for any conclusion that a more restrictive sanction was unnecessary.

49.52. The chiropractor has the right to appeal to the courts within 28 days against any decision of the PCC or HC to impose a sanction. The sanction does not take effect during these 28 days nor; if an appeal is lodged, until that appeal has been disposed of. During this time, the chiropractor's registration remains fully effective unless the committee also orders an interim suspension (see section C).

B2. General issues relevant to sanction

50.53. The Code requires chiropractors to “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” (Principle B) and to “ensure your behaviour is professional at all times, including outside the workplace, thus upholding and protecting the reputation of, and confidence in, the profession and justifying patient trust.” (Standard B5)

51.54. Certain cases are particularly serious for all aspects of the statutory over-arching objective. Some particular considerations which may arise for committees in such cases are set out in the following paragraphs.

Convictions

52.55. 'Convictions' mean findings of guilt by a criminal court in the United Kingdom (UK). A conviction by itself constitutes sufficient basis for the committee to impose a sanction, regardless of whether the criminal offence occurred in the chiropractor's professional or private life.

53.56. Should the sentence imposed by the criminal court be a conditional discharge, that does not constitute a “conviction” under English law. Nor do cautions or penalty notices administered by the police or other enforcement authorities constitute “convictions”. They may however amount to UPC.

54.57. If the committee receives in evidence a signed certificate of the conviction, then it must accept the certificate as conclusive evidence of the offence having been committed, unless it also receives evidence to the effect that the chiropractor is not the person referred to in the conviction. In these cases the purpose and focus of the proceedings is to:

a) establish whether the conviction has material relevance to the fitness of the chiropractor to practise chiropractic;

b) consider the gravity of the offence; and

c) take due account of any mitigating and aggravating circumstances. At the hearing the committee may decide to take no further action in respect of a conviction if it considers that the conviction has no material relevance to the fitness of the chiropractor concerned to practise chiropractic. However the committee may decide to impose a sanction even where the conviction occurred in the chiropractor’s private life, rather than in the course of their professional practice.

55.58. The committee cannot seek to ‘go behind’ the conviction or reach another conclusion about the matters that led to it being issued. In a hearing about a conviction, the GCC case presenter

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18 In addition, the PSA can refer to court any decision which it considers to be insufficient for the protection of the public.
19 Rule 7(1) General Chiropractic Council (Professional Conduct Committee) Rules 2000.
20 Section 22(3) Chiropractors Act 1994
will be invited to put forward evidence about the circumstances leading up to the conviction and the character and previous history of the respondent chiropractor. The chiropractor will then have the opportunity to address the committee by way of mitigation and present any evidence about this.

56.59. Committees should bear in mind that the sentence imposed by the criminal court in relation to the conviction is not always a definitive guide to the seriousness of the offence. There may have been specific personal mitigation which led the court to its decision on sentence which, in the regulatory context, carries less weight, because of the different purpose of regulatory proceedings and the public interest considerations that apply (as reflected in the over-arching objective)\(^\text{21}\). The classic explanation of this principle\(^\text{22}\) comes from the statement of Sir Thomas Bingham MR in Bolton v Law Society\(^\text{23}\) that “the reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits but that is part of the price” said, “because of these considerations, the seriousness of the criminal offence, as measured by the sentence imposed by the Crown Court, is not necessarily a reliable guide to its gravity in terms of maintaining public confidence in the profession.”

57.60. As a general principle, when a chiropractor has been convicted of a serious criminal offence, they should not be allowed to return to unrestricted practice until they have completed their criminal sentence. In CHRE v (1) General Dental Council and (2) Fleischmann, a case concerning child pornography offences, Mr Justice Newman said that: “as a general principle, where a practitioner has been convicted of a serious criminal offence or offences, he should not be permitted to resume his practice until he has satisfactorily completed his sentence. Only circumstances which plainly justify a different course should permit otherwise. Such circumstances could arise in connection with a period of disqualification from driving or time allowed by the court for the payment of a fine. The rationale for the principle is not that it can serve to punish the practitioner whilst serving his sentence, but that good standing in a profession must be earned if the reputation of the profession is to be maintained.”\(^\text{24}\)

**Sexual misconduct**

58.61. Sexual misconduct takes in a wide range of behaviour, from criminal convictions for sexual assault and sexual abuse of children (including child pornography) to sexual misconduct with patients, patients’ relatives or colleagues.

59.62. The committee should take account of the principles set out in the Code. Principle D requires chiropractors to “establish and maintain clearly defined professional boundaries between yourself and your patients to avoid confusion or harm and to protect the welfare and safety of patients and those who care for them.” Standard D1 requires chiropractors not to “abuse the position of trust which you occupy as a professional. You must not cross sexual boundaries.” The Council for Healthcare Regulatory Excellence (CHRE), the predecessor body to the PSA, produced guidance for fitness to practise panels (such as the PCC) on clear sexual boundaries.\(^\text{25}\) Committees should have regard to that guidance where relevant.

60.63. Abuse of a position of trust (such as the relationship between a chiropractor and their patient) in order to initiate or pursue a sexual relationship is likely to be considered to be an aggravating factor. It is the chiropractor’s responsibility to prevent sexual boundaries being crossed, not the patient’s.

\(^{21}\) For more information about the statutory over-arching objective, refer back to paragraph 9X

\(^{22}\) Cited in subsequent cases such as Low v General Optical Council [2007] EWHC 2839 (Admin)

\(^{23}\) [1994] 1 WLR 512

\(^{24}\) [2005] EWHC 87 (Admin)

61.64. Sexual offences include accessing, viewing or other involvement in child pornography, which involves the abuse or exploitation of a child. These types of offences are likely gravely to undermine patients' and the public's trust in the profession and seriously undermine its reputation.

62.65. The criminal courts identify degrees of seriousness in relation to child pornography offences. However, committees will usually regard any chiropractor's conviction for child pornography as potentially being a matter of very serious concern, because of the likelihood that it will damage the public's confidence in the profession as a whole.

63.66. Committees should be mindful that where someone is convicted of or receives a police caution for certain sexual offences they will also be registered on the Sex Offenders' Register. Any conviction relating to child pornography will lead to registration as a sex offender and possible inclusion on the Children's Barred List by the Disclosure and Barring Service. Committees are likely to consider such registration to be a marker of seriousness.

64.67. The committee is likely to consider that no chiropractor registered as a sex offender following a conviction or caution for a sexual offence should have unrestricted registration. In such cases, if the committee imposes conditions or suspension, it is likely to wish to order a review hearing to be held before expiry of the period of suspension/conditions.

65.68. If the committee has any significant doubt about whether a chiropractor who is no longer required to register as a sex offender should be permitted to resume unrestricted practice, it should give very careful consideration to all aspects of the over-arching objective, including the need to maintain public confidence in the profession, before deciding whether or not to impose a further sanction.

66.69. In all cases of serious sexual misconduct it will be highly likely that the only proportionate sanction will be removal from the register. If a committee decides to impose a lesser sanction in such a case, it will need to be particularly careful in explaining its reasons, so that those reasons can be clearly understood by those who did not hear the evidence in the case.

Dishonesty

67.70. Dishonesty, even when it does not result in direct harm to patients, is particularly serious because it can undermine the trust the public places in the profession. This includes dishonesty that occurs entirely outside the chiropractor-patient relationship (for example giving false statements or making fraudulent claims for money). The Privy Council has emphasised that:

“… [Authorities] must be able to place complete reliance on the integrity of practitioners; and the Committee is entitled to regard conduct which undermines that confidence as calculated to reflect on the standards and reputation of the profession as a whole.”

68.71. Principle B of the Code requires chiropractors to “act with honesty and integrity and maintain the highest standards of professional and personal conduct.”

69.72. Specifically, Standard B6 of the Code requires chiropractors to “avoid placing any undue financial pressure on a patient to commit to any long term treatment that is not justified”. Standard B7 requires chiropractors to “fulfil the duty of candour by being open and honest with every patient”, and Standard B3 requires any advertising information to be “honest and comply with all advertising codes and standards.”

70.73. Examples of dishonesty in professional practice could include:

a) defrauding a partner in the practice;

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26 As set out in section 80 Sexual Offences Act 2003
27 The length of the registration varies depending on the sentence (or caution) imposed.
28 Dey v GMC (Privy Council Appeal No 19 of 2001).
b) falsifying or improperly amending patient records;

c) submitting or providing false references, or inaccurate or misleading information on a CV;

d) failing to take reasonable steps to ensure that statements made in formal documents are accurate.

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

In all cases of dishonesty, especially when it is denied or persistent or covered up, committees are likely to wish to consider whether any sanction less than removal is appropriate, given the impact of dishonesty on public confidence in the profession.

Failing to provide an acceptable level of treatment or care

Principle A of the Code requires chiropractors to “put patients’ health first, respect them and ensure you promote their health and welfare at all times.” Principle C of the Code requires chiropractors to “uphold the high standards of the chiropractic profession by delivering safe and competent care to each patient” in all aspects of clinical practice and patient care. Committees are likely to find particularly serious any case where the chiropractor shows a reckless disregard for patient safety or where there is a breach of the fundamental duty of chiropractors to protect the patient from harm.

A particularly important consideration in such cases is whether or not a chiropractor has, or has the potential, to develop insight into these failures. If this is not evident, it is likely that conditions of practice or suspension may not be appropriate or sufficient.

The sanctions

There are four sanctions available to the PCC:

a) Admonishment;

b) Conditions of Practice Order;

c) Suspension Order;

d) Removal from the register.

There are two sanctions available to the HC when an allegation against a chiropractor that their ability to practise is seriously impaired because of a physical or mental condition is well founded:

a) Conditions of Practice Order;

b) Suspension Order.

Admonishment

The least restrictive sanction that can be applied by the PCC is an admonishment, which

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29 See Ghosh v GMC (Privy Council Appeal No 69 of 2000) and Garfoot v GMC (Privy Council Appeal No 81 of 2001).

30 The HC has no power to impose an admonishment. It may only impose a conditions of practice or suspension order.
does not directly restrict a chiropractor’s ability to practise. An admonishment may be appropriate if the allegation is at the lower end of the spectrum of unacceptable professional conduct, professional incompetence or criminal conviction, and the committee wants to mark that the behaviour of the chiropractor was unacceptable and must not happen again.

**78.81.** Admonishments may be considered when most of the following factors are present in the case (this is not a complete list):

a) evidence that the behaviour did not and would not have caused direct or indirect patient harm;

b) evidence of sufficient insight into the matters found proved;

c) the behaviour was an isolated incident, which was not deliberate;

d) a genuine expression of regret or apologies;

e) the chiropractor was acting under duress;

f) previous good history;

g) no repetition of the behaviour since the incident;

h) evidence that effective rehabilitative or corrective steps have been taken.

**79.82.** The committee will wish to consider whether it is sufficient to conclude the case with an admonishment, given:

a) the over-arching objective;

b) while imposing a sanction may have a punitive effect, that is not the purpose of imposing sanctions;

c) the reasons for the finding of unacceptable professional conduct, professional incompetence or a criminal conviction.

**80.83.** If the committee concludes that it is not sufficient to conclude the case with an admonishment, it will need to move on to consider imposing a more restrictive sanction. If the committee considers that imposing an admonishment will not be sufficient in the circumstances of the case, having regard to the over-arching objective, it must go on to consider imposing a Conditions of Practice Order on the chiropractor’s registration (see the next section).

## B5. Conditions of Practice Orders

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

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

**83.86.** The provisions within the Act surrounding the Conditions of Practice Order are slightly different depending on whether the case is being considered by the PCC or the HC.

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

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31 As per paragraph 434 the committee is likely to wish to have regard to the timing of any expression of regret or apology
Appendix B: Indicative Sanctions Guidance

a) the period for which the order is to have effect;

b) a test of competence which must be taken by the chiropractor.32

85.88 Where imposed by the PCC, a Conditions of Practice Order will end

a) if a period is specified in the Order, when that period ends;

b) if no period is specified but a test of competence is specified, when the chiropractor passes the test; or

c) if both a period and a test are specified, when the period ends or when the chiropractor concerned passes the test, whichever happens later.33

86.89 Where the HC imposes a Conditions of Practice Order, it has effect for the term specified in the Order. There is no provision in the Act for the HC to specify a test of competence.34

87.90 Given the nature and purpose of a Conditions of Practice Order, it is likely that any committee imposing such an Order, whether PCC or HC, will wish for it to be reviewed prior to its expiry. This is because the committee will wish to assess whether the chiropractor is fit to resume practice without restriction before the Order expires. In these circumstances, it is necessary for the committee to order a review hearing to be held, so that the committee can assess (in relevant cases) whether:

a) the chiropractor fully appreciates the gravity of the offence;

b) the chiropractor has not reoffended;

c) the chiropractor has maintained their skills and knowledge;

d) the chiropractor no longer has a mental or physical health condition that is seriously impairing their ability to practise;

e) patients will not be placed at risk by the chiropractor’s resumption of unrestricted practice or practice with less stringent conditions.

88.91 If the committee does not consider that a review hearing is necessary, it should clearly explain its reasons in its determination. Providing clear reasons for that decision is particularly helpful if at a later date that decision has to be reconsidered, as set out in paragraph 920 below.

89.92 Where a committee does not order a review hearing, if a change in circumstances leads the GCC to consider that it is necessary for the sanction to be reviewed, it can apply to bring the case back before the PCC or HC at any point before the expiry of the order. The committee’s original reasons for not directing a review may be relevant to any decision that is then taken.

90.93 Where a review hearing has been ordered but circumstances arise which mean the GCC considers that the review hearing should be heard earlier than scheduled the GCC can apply to the committee for an early review to be held.

91.94 There is more detail about review hearings and the options available to the committee when reviewing a sanction at section D.

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

a) the chiropractor to know what is expected of them; and

b) the committee at any future review hearing to be able to understand the chiropractor’s original shortcomings and the specific actions needed to correct them.

32 Section 22(5) Chiropractors Act 1994
33 Section 22(6) Chiropractors Act 1994
34 Section 23(3) Chiropractors Act 1994
Only when the objectives are set out clearly will it be possible to evaluate whether they have been achieved. Any conditions must be:

a) specific;
b) appropriate;
c) proportionate;
d) workable;\(^{35}\)
e) measurable.

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

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

Committees should refer to the GCC’s Bank of Conditions when deciding which conditions to impose in any particular case.

Before the committee decides on any conditions to be imposed, it should consider inviting any comments from the GCC and the chiropractor concerned about whether or not the proposed conditions will be workable. Seeking such comments may mean the committee needs to adjourn for a brief period of time in order to allow the GCC and chiropractor an opportunity for consideration.

A Conditions of Practice Order may be appropriate when most or all of the following are apparent in the case (this is not a complete list):

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

\(^{35}\) Committees must take care to ensure that the conditions imposed are not so restrictive as to be tantamount to a Suspension Order. In circumstances where a committee is unable to formulate workable conditions that sufficiently protect the public, it is likely to be appropriate instead to consider a Suspension Order.
The committee will wish to consider whether it is sufficient to conclude the case with conditions imposed upon registration, given:

- the over-arching objective;
- while imposing a sanction may have a punitive effect, that is not the purpose of imposing sanctions;
- the reasons for the finding of unacceptable professional conduct, professional incompetence, a criminal conviction or impairment by reason of health.

If the Committee concludes that it is not sufficient to conclude the case with a Conditions of Practice Order it will need to move on to consider imposing a more restrictive sanction.

### B6. Suspension

A Suspension Order directs the Registrar to suspend the chiropractor’s registration for a period of up to three years. The chiropractor must not practise as a registered chiropractor.

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

Suspension is the most restrictive sanction available to the HC.

Whether imposed by the PCC or the HC, the length of suspension may be up to three years. The length of a suspension is for the committee to decide on; it must impose the minimum required for protection of the public and the wider public interest in the circumstances of the particular case.

In some UPC cases – for example those where there is well-developed insight, remorse, proper remediation and no risk of repetition – it may be self-evident that, following a short suspension there would be no value in a review hearing. However, in most cases where a period of suspension is imposed the committee will need to be reassured that the chiropractor is fit to resume practice – either unrestricted or with conditions – upon the expiry of the Order. In these circumstances, it is necessary for the committee to order for a review hearing to be held in order that the committee can assess whether:

- the chiropractor fully appreciates the gravity of the offence;
- the chiropractor has not reoffended;
- the chiropractor has maintained their skills and knowledge;
- the chiropractor no longer has a mental or physical health condition that is seriously impairing their ability to practise;
- patients will not be placed at risk by the resumption of practice or by the imposition of conditional registration.

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

Where a committee does not order a review hearing, if a change of circumstances leads the GCC to consider that it is necessary for the sanction to be reviewed, it can apply to bring the case back before the PCC (or HC) at any point before the expiry of the Order. The committee’s reasons for not directing a review may be helpful in informing any decision.
108. Where a review hearing has been ordered, but circumstances arise which mean the GCC considers that the review hearing should be heard earlier than scheduled, the GCC can apply to the committee for an early review to be held.

109. There is more detail about review hearings and the options available to the committee when reviewing a sanction at section D.

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

111. Suspension Orders may be appropriate when some or all of the following are apparent in the case (this is not a complete list):
   a) there has been a serious breach of the Code and, while the UPC concerned is not fundamentally incompatible with continued registration, the breach is so serious that any sanction lower than a suspension would not be sufficient in view of the requirements of the statutory over-arching objective;
   b) the case involves professional incompetence where there is a risk to patient safety if the chiropractor's registration is not suspended, and the chiropractor demonstrates potential and willingness to remediate their deficiencies and failings;
   c) there is no evidence of harmful deep-seated personality or attitudinal problems;
   d) there is no evidence of repetition of similar behaviour since the incident;
   e) the committee is satisfied the chiropractor has insight and does not pose a significant risk of repeating the behaviour.

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

113. Suspension from the register will have a punitive effect, in that it prevents a chiropractor from practising (and therefore earning a living as a chiropractor) during the period of the order. It is also likely to have a longer-term adverse effect on the individual's reputation. The committee will be mindful of the principle of proportionality set out at paragraphs 27-29-31 - once it determines that a period of suspension is necessary to protect the public, that sanction must be imposed, even where that may have a negative impact on the practitioner. This is necessary so as to fulfil the statutory over-arching objective. Case law has established that it can never be an objection to suspension that the chiropractor may be unable to re-establish his practice when the period has ended.\[^{36}\]

114. The PCC will wish to consider whether it is sufficient to conclude the case by suspending the chiropractor’s registration, given:
   a) the over-arching objective;

\[^{36}\] Bolton v Law Society
b) the purpose of imposing sanctions is not to be punitive but to protect patients and the wider public interest;

c) the reasons for the finding of unacceptable professional conduct, professional incompetence, criminal conviction.

If the PCC concludes that it is not sufficient to conclude the case with a suspension, it will need to order the removal of the chiropractor’s name from the register.\(^\text{37}\)

In cases when the PCC or the HC decides to impose a Suspension Order, the committee should also seriously consider whether it needs to impose an Interim Suspension Order in order to protect members of the public during the period until the Suspension Order comes into effect.\(^\text{38}\). A Suspension Order does not take effect for 28 days and, if an appeal is lodged, not until the appeal has been decided, during which time the chiropractor would remain on the register and be able to practise if an Interim Suspension Order has not also been imposed.

**B7. Removal from the register**

This sanction requires the Registrar to remove the chiropractor’s name from the register, thus prohibiting that individual from working as a chiropractor in the UK. Removal from the register may well be necessary when the behaviour involves any of the following (this is not a complete list):

a) particularly serious departure from the principles set out in the Code; that is, behaviour fundamentally incompatible with being a chiropractor;

b) a reckless disregard for the principles set out in the Code and for patient safety;

c) doing serious harm to others (patients or otherwise), either deliberately or through incompetence; particularly where there is a continuing risk to patients (see further guidance at paragraphs 736-747 about failure to provide an acceptable level of treatment or care);

d) abuse of position of trust;

e) violation of a patient’s rights or exploiting vulnerable people;

f) offences of a sexual nature, including involvement in child pornography (see paragraphs 5618-669);

g) offences involving serious violence that have resulted in a custodial sentence;

h) dishonesty, especially when it is denied, persistent or covered up (see paragraphs 6770-725);

i) acting without integrity and abusing professional standing;

j) persistent lack of insight into the seriousness of their actions or the consequences.

Protection of the public and upholding the public interest are the most important considerations when deciding the appropriate sanction. Lord Bingham, Master of the Rolls, in the case of *Bolton v The Law Society*, stated that:

"Because orders made by the tribunal are not primarily punitive, it follows that considerations which would ordinarily weigh in mitigation of punishment have less effect on the exercise of this jurisdiction than on the ordinary run of sentences imposed in criminal cases. It often happens that a solicitor appearing before the tribunal can adduce a wealth of glowing tributes from his professional brethren."

\(^{37}\)The HC has no power to remove a chiropractor from the register; a Suspension Order is the most restrictive sanction available to it.

\(^{38}\) Section 24(2) Chiropractors Act 1994
He can often show that for him and his family the consequences of striking off or suspension would be little short of tragic. Often he will say, convincingly, that he has learned his lesson and will not offend again. On applying for restoration after striking off, all these points may be made, and the former solicitor may also be able to point to real efforts made to re-establish himself and redeem his reputation. All these matters are relevant and should be considered. But none of them touches the essential issue, which is the need to maintain among members of the public a well-founded confidence that any solicitor whom they instruct will be a person of unquestionable integrity, probity and trustworthiness. Thus it can never be an objection to an order of suspension in an appropriate case that the solicitor may be unable to re-establish his practice when the period of suspension is past. If that proves, or appears likely to be, so the consequence for the individual and his family may be deeply unfortunate and unintended. But it does not make suspension the wrong order if it is otherwise right. The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is a part of the price."

The judgment in Gupta v The General Medical Council, which followed the approach set out in Bolton v The Law Society, emphasised the General Medical Council's role in maintaining justified confidence in the profession. In particular, it stated that removal was appropriate when, despite a practitioner presenting no risk:

"... the appellant's behaviour demonstrated a blatant disregard for the system of registration which is designed to safeguard the interests of patients and to maintain high standards within the profession."

In the case of Bijl v the GMC, which involved two clinical errors of judgement and mistakes relating to one operation performed by Dr Bijl, the Privy Council stated that a committee should not feel it necessary to remove:

"an otherwise competent and useful doctor who presents no danger to the public in order to satisfy [public] demand for blame and punishment"

and drew attention to the statement that:

"honest failure should not be responded to primarily by blame and retribution but by learning and by a drive to reduce risks for future patient.

There are some examples of misconduct where the Privy Council has upheld decisions to remove health practitioners from registers despite strong mitigation. This has been because it would not have been in the public interest to do otherwise given the circumstances of the case.

In cases where the committee decides to remove a chiropractor from the register (that is, imposes a Removal Order), it should also seriously consider whether it is necessary to impose an Interim Suspension Order in order to protect members of the public during the period before the removal takes effect (section 24(2) of the Chiropractors Act 1994 - see section C). A Removal Order does not take effect for 28 days and, if an appeal is made, not until the appeal has been decided, during which time the chiropractor would remain on the register and be able to practise.

[2002] 1 WLR 1691
Section C: Interim suspension

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

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

125.128. In practice, it is arguable that, if it is considered necessary to suspend or remove a chiropractor from the register, interim suspension should always be considered as a logical step to protect the public during the period in which the chiropractor may appeal the sanction. The decision about whether or not to impose an Interim Suspension Order is one that the committee will approach based on the individual facts of the case.

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40 Section 24 Chiropractors Act 1994.
Section D: Review hearings

126.129. As already set out at paragraphs 8790 and 1058, when a committee decides that a period of registration with conditions or suspension is appropriate, it will normally order that a review hearing be held, because the committee will want to ensure that the chiropractor is fit to resume practice before the order lapses.

127.130. It is important that no chiropractor should be allowed to resume unrestricted practice following a period of conditional registration or suspension unless the committee considers that they are safe to do so. The committee will need to be reassured that the chiropractor is fit to resume practice either unrestricted, or with conditions, or further conditions. The committee will also need to satisfy itself (as relevant) that:

a) the chiropractor has fully appreciated the gravity of the offence;
b) the chiropractor has not reoffended;
c) the chiropractor has maintained their skills and knowledge;
d) the chiropractor’s ability to practise is no longer seriously impaired by a mental or physical condition; and
e) patients will not be placed at risk by resumption of practice or by the imposition of conditional registration.

128.131. In cases where the chiropractor was required to register as a sex offender following a conviction or caution for a sexual offence, at any review hearing the reviewing committee is likely to wish to take into account the following factors:

a) whether the registration requirement has ceased;
b) the seriousness of the original offence;
c) evidence about the chiropractor’s response to any treatment programme they have undertaken;
d) the level of insight shown by the chiropractor into the seriousness of their previous actions;
e) the likelihood of the chiropractor re-offending;
f) any possible risk to patients and the wider public if the chiropractor is allowed to resume unrestricted practice;
g) any possible damage to public confidence in the profession if the chiropractor is allowed to resume unrestricted practice;
h) whether any risk to patients and the wider public could be adequately managed by the placing of restrictions on the chiropractor’s registration.

129.132. The committee should consider whether the chiropractor has produced any information or objective evidence on these matters.

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

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

a) extend, or further extend, the period for which the order has effect;
b) revoke or vary any of the conditions;

c) require the chiropractor to pass a test of competence specified by the Committee;

d) reduce the period for which the order has effect; or

e) revoke the order.41

132.135. Where the PCC extends or reduces the Conditions of Practice Order, or specifies a test of competence, as described in paragraph 814 above, the order will have effect as if:

a) the period specified in the Conditions of Practice Order was the extended or reduced period; and

b) a test of competence was specified in that Order.

133.136. Where the HC has imposed a Conditions of Practice Order, at any time the Order is in force, it may (whether or not of its own motion):

a) extend, or further extend, the period for which the Order has effect; or

b) make a Suspension Order.42

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

a) revoke the Order;

b) vary the Order by reducing the period for which it has effect; or

c) vary the Order by removing or altering any of the conditions.43

135.138. Where a chiropractor makes an application to the HC as described in paragraph 1347, and the application is refused, the HC will not entertain a further such application unless it is made after the end of the period of twelve months beginning with the date on which the previous application was reviewed by the committee.

136.139. Where the PCC has imposed a Suspension Order, at any time while that Order is in force, the PCC may (whether or not of its own motion):

a) extend, or further extend, the period of suspension; and

b) make a Conditions of Practice Order with which the chiropractor must comply if they resume the practice of chiropractic after the end of the period of suspension.44

137.140. Where the HC has imposed a Suspension Order, at any time while that Order is in force, the HC may (whether or not of its own motion):

a) extend, or further extend, the period of suspension;

b) replace the order with a Conditions of Practice Order having effect for the remainder of the period of suspension; or

c) make a Conditions of Practice Order with which the chiropractor must comply if they resume the practice of chiropractic after the end of the period of suspension.45

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

a) revoke the Order;

41 Section 22(7) Chiropractors Act 1994
42 Section 23(4) Chiropractors Act 1994
43 Section 23(6) Chiropractors Act 1994
44 Section 22(9) Chiropractors Act 1994
45 Section 23(5) Chiropractors Act 1994
b) vary the Order by reducing the period for which it has effect. 46

139. Where a chiropractor makes an application as described in paragraph 138, which is refused, the HC shall not entertain a further such application unless it is made after the end of the period of twelve months beginning with the date on which the previous application was reviewed by the HC.

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

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

142. Where a reviewing committee imposes a further sanction, it should consider whether or not to direct a further review hearing be held. In most cases a further review hearing will be necessary, because the committee will again want to check the chiropractor’s compliance with the order before it expires. Where a committee decides not to direct a review hearing be held, it must give reasons to make it clear that the matter has been considered, and explain the basis of the decision not to direct that a review hearing be held.

46 Section 23(6) Chiropractors Act 1994
Appendix A: Checklist of sanctions and relevant factors

Admonishment

1. Admonishments may be considered when most of the following factors are present in the case (this is not a complete list):
   a) evidence that the behaviour did not and would not have caused direct or indirect patient harm;
   b) evidence of sufficient insight into the matters found proved;
   c) the behaviour was an isolated incident, which was not deliberate;
   d) a genuine expression of regret or apologies;\(^\text{47}\)
   e) the chiropractor was acting under duress;
   f) previous good history;
   g) no repetition of the behaviour since the incident;
   h) evidence that effective rehabilitative or corrective steps have been taken;
   i) relevant and appropriate references and testimonials.

2. The committee will wish to consider whether it is sufficient to conclude the case with an admonishment, given:
   a) the over-arching objective;
   b) while imposing a sanction may have a punitive effect, that is not the purpose of imposing sanctions;
   c) the reasons for the finding of UPC, professional incompetence or a criminal conviction.

3. If the committee concludes that it is not sufficient to conclude the case with an admonishment, it will need to move on to consider imposing a more restrictive sanction.

Conditions of Practice Order

4. A Conditions of Practice Order may be appropriate when most or all of the following are apparent in the case (this is not a complete list):
   a) there is no evidence of harmful deep-seated personality or attitudinal problems;
   b) there are identifiable areas of a chiropractor's practice in need of review, retraining or assessment;
   c) there is no evidence of general incompetence;
   d) there is evidence of a willingness to undertake, and the potential to respond positively to, further training and assessment (where the allegation does not relate solely to ill-health);
   e) the chiropractor has insight into any health problems seriously impairing their ability to practise and is prepared to agree to abide by conditions relating to medical condition,

\(^{47}\) As per paragraph 434 the committee is likely to wish to have regard to the timing of any expression of regret or apology
5. The committee will wish to consider whether it is sufficient to conclude the case with conditions imposed upon registration, given:
   a) the over-arching objective;
   b) while imposing a sanction may have a punitive effect, that is not the purpose of imposing sanctions;
   c) the reasons for the finding of UPC, professional incompetence, a criminal conviction or impairment by reason of health

6. If the Committee concludes that it is not sufficient to conclude the case with a Conditions of Practice Order it will need to move on to consider imposing a more restrictive sanction.

**Suspension**

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

8. Suspension Orders may be appropriate when some or all of the following are apparent in the case (this is not a complete list):
   a) there has been a serious breach of the Code and, while the unprofessional conduct concerned is not fundamentally incompatible with continued registration, the breach is so serious that any sanction lower than a suspension would not be sufficient in view of the requirements of the statutory over-arching objective;
   b) the case involves professional incompetence where there is a risk to patient safety if the chiropractor's registration is not suspended, and the chiropractor demonstrates potential and willingness to remediate their deficiencies and failings;
   c) there is no evidence of harmful deep-seated personality or attitudinal problems;
   d) there is no evidence of repetition of similar behaviour since the incident;
   e) the committee is satisfied that the chiropractor has insight and does not pose a significant risk of repeating the behaviour.

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

10. The PCC will wish to consider whether it is sufficient to conclude the case with registration being suspended, given:
   a) the over-arching objective;
   b) the purpose of imposing sanctions is not to be punitive but to protect patients and the wider public interest;
   c) the reasons for the finding of UPC, professional incompetence or a criminal conviction.

11. If the PCC concludes that it is not sufficient to conclude the case with a Suspension Order, it will need to order the removal of the chiropractor’s name from the register. 48

**Removal from the register**

12. This sanction requires the Registrar to remove the chiropractor’s name from the register, thus prohibiting that individual from working as a chiropractor in the UK. Removal from the register may well be necessary when the behaviour involves any of the following (this is not a complete list):
   a) particularly serious departure from the principles set out in the Code; that is, behaviour fundamentally incompatible with being a chiropractor;
   b) a reckless disregard for the principles set out in the Code and for patient safety;
   c) doing serious harm to others (patients or otherwise), either deliberately or through incompetence; particularly where there is a continuing risk to patients (see further guidance at paragraphs 736-747 about failure to provide an acceptable level of treatment or care);
   d) abuse of a position of trust;
   e) violation of a patient’s rights or exploiting vulnerable people;
   f) offences of a sexual nature, including involvement in child pornography (see paragraphs 5861-669);
   g) offences involving serious violence that have resulted in a custodial sentence.
   h) dishonesty, especially when it is denied, persistent or covered up (see paragraphs 6770-725);
   i) acting without integrity and abusing professional standing;.
   j) persistent lack of insight into the seriousness of their actions or the consequences.

13. In cases where the committee decides to remove a chiropractor from the register (that is, imposes a Removal Order), it should also seriously consider whether it is necessary to impose an Interim Suspension Order in order to protect members of the public during the period before the removal takes effect (section 24(2) of the Chiropractors Act 1994 - see section C). A Removal Order does not take effect for 28 days and, if an appeal is made, not until the appeal has been decided, during which time the chiropractor would remain on the register and be able to practise.

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48The HC has no power to remove a chiropractor from the register; a Suspension Order is the most restrictive sanction available to it.
## GCC Conditions Bank

Conditions can be imposed on a chiropractor's registration by the Professional Conduct (PCC) or Health Committee (HC) following a finding at a PCC/HC hearing. This document sets out wording that the PCC or HC panels should use when imposing conditions. It can be adapted as appropriate. It should be read alongside the Indicative Sanctions Guidance.

Conditions marked “C” are confidential and information about them will not be disclosed on the online register.

<table>
<thead>
<tr>
<th>General Chiropractic Council Conditions Bank</th>
<th>Confidential (C) / Non-confidential (NC)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workplace supervision</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C1 At any time you are providing chiropractic services which require you to be registered with the GCC, you must place yourself and remain under the supervision of a workplace supervisor, who shall be a registered chiropractor to be approved by the GCC.</td>
<td>NC</td>
<td>Committee to define the level of supervision it has in mind</td>
</tr>
<tr>
<td>C2 You will cooperate with your workplace supervisor and make available all such information, documentary and oral, that he/she requires in order to fulfil his/her supervisory role.</td>
<td>NC</td>
<td>Applicable in cases where the committee has concerns about the chiropractor’s professional performance.</td>
</tr>
<tr>
<td>C3 You must allow your workplace supervisor to provide reports to the GCC at intervals of not more than [?] months.</td>
<td>NC</td>
<td>Committee must determine the timeframe for reporting.</td>
</tr>
<tr>
<td>C4 You must keep your professional commitments under review and limit your chiropractic practice in accordance with your workplace supervisor’s advice.</td>
<td>NC</td>
<td></td>
</tr>
<tr>
<td>C5 You must advise all current patients that your records and appointments are subject to review by your workplace supervisor.</td>
<td>NC</td>
<td>Applicable in cases where the committee has concerns about the chiropractor’s professional performance. Appropriate to include in every case where conditions relating to audit or observation by a third party are imposed.</td>
</tr>
</tbody>
</table>
### Personal Development Plan

| C6   | You shall work with a workplace supervisor to prepare a Personal Development Plan (PDP) specifically designed to address the deficiencies in the following areas of your practice:  

[List areas requiring development]  

| NC   | Applicable in cases where the committee has concerns about the chiropractor’s professional performance.  

To be used in conjunction with conditions regarding the workplace supervisor (see CX – CY)  

Committee to list areas which require development. |
| C7   | You must forward a copy of your PDP to the GCC within [? ] months of the date on which these conditions become effective.  

| NC   | Committee must specify length of time.  

Applicable in cases where the committee has concerns about the chiropractor’s professional performance. |
| C8   | You must arrange to meet your workplace supervisor [?] in order to discuss your progress towards achieving the aims set out in your PDP.  

| NC   | Applicable in cases where the committee has concerns about the chiropractor’s professional performance.  

Committee to determine the appropriate interval for such meetings to take place. |
| C9   | You must allow the GCC to exchange information about the standard of your professional performance and your progress towards achieving the aims set out in your PDP with your supervisor, and with any other person involved in your retraining and supervision.  

| NC   | Applicable in cases where the committee has concerns about the chiropractor’s professional performance. |
## Auditing areas of practice

<table>
<thead>
<tr>
<th>Appendix B C-1803/7</th>
</tr>
</thead>
</table>
| **C10** You will be subject to an audit process to be undertaken by an Auditor, who will be a registered chiropractor appointed by the GCC, to audit the following aspects of your practice:  
[List areas to be audited] | NC | Applicable in cases where the committee has concerns about the chiropractor’s professional performance.  
Committee to list areas to be audited. |
| **C11** You will cooperate with the Auditor and make available all such information, documentary and oral, that he/she requires in assessing the standard of your practice. | NC | Applicable in cases where the committee has concerns about the chiropractor’s professional performance. |
| **C12** At each audit the Auditor will select a random sample of at least [?] records to be audited. | NC | Applicable in cases where the committee has concerns about the chiropractor’s professional performance.  
Committee to decide on the number of records to be audited. |
| **C13** At each audit / at intervals of [?] months the Auditor will observe a minimum of [?] patient appointments to observe and assess the standard of your practice, focusing on but not limited to the following areas:  
*List areas requiring audit by direct observation* | | Applicable in cases where the committee has concerns about the chiropractor’s professional performance.  
Committee to decide on the frequency of audit and the areas to be audited. |
| **C14** The audits will take place at intervals of [?] months from the commencement of this Order. | NC | Applicable in cases where the committee has concerns about the chiropractor’s professional performance.  
Committee to decide on the appropriate intervals for audits. |
| **C15** You must advise all current patients that your records and/or appointments are subject to review and audit by a registered chiropractor. | NC | Applicable in cases where the committee has concerns about the chiropractor’s professional performance.  
Appropriate to include in every case where conditions relating to audit and/or observation by a third party are imposed. |
## Practice restrictions

<table>
<thead>
<tr>
<th>C16</th>
<th>You must restrict your chiropractic practice to [?] sessions per week.</th>
<th>NC</th>
</tr>
</thead>
<tbody>
<tr>
<td>C17</td>
<td>You must refrain from carrying out [name of procedure]</td>
<td>NC</td>
</tr>
<tr>
<td>C18</td>
<td>You must not carry out [name of procedure] unless directly supervised by another chiropractor registered with the GCC.</td>
<td>NC</td>
</tr>
<tr>
<td>C19</td>
<td>You must not carry out [name of procedure] unless in the presence of a chaperone.</td>
<td>NC</td>
</tr>
<tr>
<td>C20</td>
<td>You must not carry out [name procedure] until you have completed a course or courses on [name area of practice or relevant procedure] which is/are acceptable to the GCC. You must provide evidence to the committee of your successful completion of such course(s) in advance of the committee’s review of your case.</td>
<td>NC</td>
</tr>
</tbody>
</table>

Applicable in cases where the committee has concerns about the chiropractor’s professional performance.

Committee to decide on the extent to which patient interactions need to be chaperoned.

Committee to decide on the type of course/courses to be undertaken.

## Targeted assessment of performance

<table>
<thead>
<tr>
<th>C21</th>
<th>Your competence in the following techniques will be tested by an assessor to be appointed by the GCC: [List areas to be assessed]</th>
<th>NC</th>
</tr>
</thead>
</table>


Applicable in cases where the committee has concerns about the chiropractor’s professional performance.

Committee to list areas which require assessment.

Committee should restrict chiropractor’s practice in these areas until such a time as the chiropractor has been assessed as competent.

| C22 | You will be responsible for payment of any fees associated with the test of your competence by the GCC-appointed assessor. | NC |

Applicable in cases where the committee has concerns about the chiropractor’s professional performance.

Committee to list areas which require assessment.

Committee should restrict chiropractor’s practice in these areas until such a time as the chiropractor has been assessed as competent.
<table>
<thead>
<tr>
<th>Health issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C23</strong> You must register and remain under the care of a general medical practitioner and inform him/her that you are subject to these conditions. You must attend appointments and follow their advice.</td>
</tr>
<tr>
<td><strong>C24</strong> You must abstain completely from the consumption of alcohol.</td>
</tr>
<tr>
<td><strong>C25</strong> You must abstain completely from the taking of [drugs].</td>
</tr>
<tr>
<td><strong>C26</strong> You must limit your alcohol consumption in accordance with medical advice.</td>
</tr>
<tr>
<td><strong>C27</strong> You must take drugs only as prescribed for you by your general practitioner or any medical or dental professional responsible for your care.</td>
</tr>
<tr>
<td><strong>C28</strong> You must comply with arrangements made by, or on behalf of the GCC, for the [announced/unannounced] testing of [breath/blood/urine/saliva/hair] for the recent and long term ingestion of alcohol and other drugs.</td>
</tr>
<tr>
<td><strong>C29</strong> You must remain under the care of a treating psychiatrist and must allow the GCC to exchange information with them about your condition and the treatment you are receiving.</td>
</tr>
<tr>
<td><strong>C30</strong> You must work with the professionals involved in your care to formulate a PDP specifically designed to assist you in returning to unrestricted practice. You must forward a copy of this PDP to the GCC within 3 months of the date on which these conditions become effective.</td>
</tr>
</tbody>
</table>
### Payment of fees

| C31 | You shall be responsible for paying for the costs of your [supervision / audit / audit reports / drug testing / alcohol testing] and shall pay the relevant invoice within 28 days. | NC | C insofar as relates to health conditions | Committee to amend as appropriate depending on the other conditions imposed. |

### Reflective piece / learning diary

| C32 | You shall prepare a reflective piece to address how you have developed personally and as a practitioner, to be submitted to the reviewing committee [?] days before any review hearing. | NC |  |

| C33 | You will produce a learning diary to provide evidence to a reviewing committee that you have updated your knowledge and skills to enable you to:-

- [Committee to list relevant areas of practice]

Such evidence may take the form of course attendance certificates and/or notes of self-directed learning and any other evidence you consider would assist the Committee | NC |  |
To: The General Chiropractic Council  
From: Chief Executive & Registrar  
Subject: Revised Indicative Sanctions Guidance for the Professional Conduct Committee and the Health Committee  
Date: 21st March 2018

Purpose

1. The GCC consultation on the revised Indicative Sanctions Guidance and proposed bank of template conditions for use by the Professional Conduct Committee and Health Committee closed on 9 March 2018, after a 12-week consultation period.

2. We received a late response to the consultation from the Alliance of UK Chiropractors (AUKC) on 16 March 2018. This paper contains the comments made by the AUKC and the GCC’s response on each comment. It also sets out any further changes it is proposed should be made to the Indicative Sanctions Guidance and bank of template conditions as a result of receipt of these comments.

3. Council is asked to have regard to this paper when considering paper C-1803/7.

Background

4. Council members already have paper C-1803/7 and its Appendices A and B. Appendix A provides information about the responses to the consultation that were received on or before the end of the consultation period. Appendix B contains the text of the revised Indicative Sanctions Guidance and bank of template conditions, showing the changes it is proposed should be made following consideration of the comments made during the consultation.

5. The AUKC contacted the CER on 18 March to report that the AUKC had not submitted a response by the deadline because of a misunderstanding around the consultation’s end date. It was agreed that the AUKC’s comments would be shared so that the Council could consider them along with the other consultation responses.

6. In responding to the specific consultation questions, the AUKC was supportive of the contents of the revised ISG and of the introduction of a bank of template conditions for use by the PCC and HC. The AUKC also provided some specific comments about aspects of the revised ISG and the application of the template bank of conditions. The response is annexed, along with the GCC’s response to the comments made by the AUKC. Where it is proposed to further amend the wording of the revised ISG/bank of template conditions (at Appendix B to paper C-1803/7) as a result of the AUKC’s comments, that is also highlighted.

Equality and diversity implications

7. None have been identified.
**Financial implications**

8. The resource implications arising from the publication of the revised guidance are discussed in paper C-1803/7.

**Legal or Risk Implications**

9. The legal or risk implications that may arise are discussed in paper C-1803/7.

**Communications implications**

10. The communications implications arising from the revised ISG guidance and bank of template conditions are addressed in paper C-1803/7.

**Action**

11. Council is asked to take account of this paper when considering paper C-1803/7.
AUKC comments on Indicative Sanctions Guidance Consultation

The Alliance of UK Chiropractors (AUKC) welcomes the consultation on Indicative Sanctions Guidance (ISG) for the Professional Conduct Committee (PCC) and Health Committee (HC) and broadly supports the introduction of a bank of sanctions. This bank should serve to assist the PCC and HC in making consistent and workable conditions of practice and also to assist Chiropractors in understanding what the possible sanctions might be.

The AUKC is concerned, however, that there is a general lack of awareness or consideration throughout the documents of the type of employment situations chiropractors find themselves in. A large proportion of chiropractors in the UK are self-employed sole practitioners, either working alone, or within a multidisciplinary setting where they are the only chiropractor. Self-employed, independent practitioner status is also often the case even within group practices. This severely limits or impedes the opportunities for workplace supervision. Further, additional guidance on how this requirement can be achieved will be necessary to address this situation. For example, within the counselling profession, practitioners have a monthly supervision session either in person, by Skype or by telephone. If daily or constant supervision/chaperones are required, this then becomes logistically impossible for some, expensive and difficult to manage for both the Registrant and the GCC.

GCC response: We recognise that putting arrangements in place around workplace supervision is more challenging when the professionals involved frequently work alone.

We propose to amend current paragraph 100 of the Indicative Sanctions Guidance to add further emphasis to the importance of any committee imposing conditions first ensuring that those conditions are workable.

If amended (as shown in red font below) paragraph 100 would read “Before the committee decides on any conditions to be imposed, it should consider inviting any comments from the GCC and the chiropractor concerned about whether or not the proposed conditions will be workable. This is likely to be particularly important if the committee intends to impose conditions requiring workplace supervision. Seeking such comments may mean the committee needs to adjourn for a brief period of time in order to allow the GCC and chiropractor an opportunity for consideration”.

A4; para 13: The purpose of sanctions is not to punish, but sanctions may have a punitive effect: and further along at A6; para 27: In deciding what sanction to impose, the committee must consider the principle of proportionality. This means that when considering what sanction to impose in order to fulfil the statutory overarching objective, the committee must take into consideration the interests of the chiropractor

We would hope that the PCC is always mindful of this when considering sanctions.

GCC response: no change required to guidance.

A7; para 35: In some cases, the stage of the chiropractor’s career may be a mitigating factor - for example because the chiropractor was very inexperienced at the time of relevant events but has subsequently been able to reflect on how they might have done things differently, with the benefit of experience.
A concern here is that if there are findings such as this on a regular basis then this calls into question the suitability of the chiropractic programs (both at universities and the RCC) to prepare a chiropractor for practice in the public arena. As such, if regular findings are related to this, even to graduates of a particular institution, then an enquiry should be made.

With respect to the stage of a Chiropractor's career as a mitigating factor, the newly qualified might be considered very cautious practitioners who would learn from mistakes made, but equally, it is incumbent on experienced practitioners to keep up to date and be open to continually improving their practice and skills.

GCC response: The Indicative Sanctions Guidance is focused on the exercise the committee undertakes with regard to deciding on the appropriate sanction, once it has already made a finding of UPC. There is therefore no risk that it will affect the findings committees make about the facts or about whether or not unacceptable professional conduct has been established.

The Guidance makes it clear that the relevance of any evidence presented in mitigation (whether concerning the chiropractor's relative inexperience at the time or some other mitigating factor) will be judged in the context of that individual case. See paragraph 33 (originally paragraph 31).

We agree that outcomes from hearings may be relevant to our evaluation of chiropractic education programmes as well as analysis of risk and the development of guidance and will look for ways in which to ensure that learning is shared across our regulatory functions.

No change to the Indicative Sanctions Guidance is required in response to these comments.

At section 44 the reference to cross cultural communications and expressions of remorse, might also include some reference to autism spectrum disorders and individuals with health conditions that might impair their social skills in expressing remorse. Are members of the PCC suitably qualified to recognise these communication variabilities? If not, should consideration be given to either train them, or recruit lay members with a speciality in this important area.

GCC response: We propose amending current paragraph 47 of the Indicative Sanctions Guidance to include a reference to committees taking account of any independent expert evidence presented by the chiropractor that establishes the existence of a health condition that affects that chiropractor’s expression of remorse. Current paragraph 47 would read (amendment shown in red font):

“Committees should be aware that different practitioners may express insight and/or remorse in different ways. Cross-cultural communication studies show that there are significant differences in the way that people from different culture and language groups use language and non-verbal signals both to understand what is being said and to express themselves. This is particularly the case when individuals are using a second language. Committees should also have regard to any independent expert evidence presented by a practitioner that establishes that they have a particular health condition that impacts on the way in which they express remorse. Awareness of and sensitivity to these issues are important in considering and assessing the degree of insight or remorse shown.”
In section 53 reference is made to criminal convictions and that cautions and penalty notices do not constitute convictions. Then section 55 states that ‘the committee cannot seek to ‘go behind’ the conviction’. It seems to us that this should apply equally to cautions and penalty notices and that Registrants should not need to declare these until a conviction has been made.

GCC response: There appears to have been a misunderstanding by the AUKC about what it means to say that a committee cannot “go behind” a conviction. That phrase means that the committee must accept, based on the certificate of conviction (or other official court document establishing the outcome) that the chiropractor has been convicted of the offence in question, and (unlike where the allegation is one of unacceptable professional conduct) the committee must not seek to decide on the facts for itself. This wording has no relevance to the timing of when chiropractors are required to declare convictions. No amendment to the Indicative Sanctions Guidance is required.

Section 70 refers to examples of dishonesty and item a) Defrauding a partner in the practice. Surely this falls into the category of inter practitioner disputes which generally, the GCC does not consider? Perhaps some additional information could be added here?

GCC response: The Indicative Sanctions Guidance contains guidance for committees to apply when considering sanctions. It is therefore relevant once the committee in the case in question has already decided that unacceptable professional conduct (UPC) has been established. The AUKC’s comment concerns whether or not “defrauding a partner in the practice” should be considered as UPC in the first place.

We assume that the AUKC’s comment is based on the reference in the “fitness to practise explanation” issued in March 2015 that “complaints solely about business disputes” and “complaints solely about employment, contracts or business premises” would not usually be investigated.

We note that the dictionary definition of “defraud” is “to take something illegally from a person, company, etc., or to prevent someone from having something that is legally theirs by deceiving them”. It is our view that defrauding a partner cannot properly be said to fall into the category of a mere “business dispute”, as it necessarily involves an intentional deception in order to deprive another of something that is legally theirs i.e. it involves a lack of integrity and/or honesty. The Indicative Sanctions Guidance explains why dishonesty and lack of integrity are viewed seriously. No amendment to the Guidance is proposed.

If a Conditions of Practice order has been made, and there is a condition of passing a TOC before resuming full practice, would failing the TOC mean removal from the Register, continuation of the Conditions order, or would a retest be permitted? It seems a little unclear.

GCC response: Section D of the Indicative Sanctions Guidance sets out the options open to a committee when reviewing a Conditions of Practice Order, as set out in the legislative framework. The committee has no power to order removal from the register in these circumstances. It does have power to extend the conditions or to vary them (e.g. by requiring re-testing) and to order a further review hearing to take place (see paragraph 134 and 145).
We have considered whether there is any additional wording that could be inserted into the Guidance to clarify, but have concluded that there is not.

CONSULTATION QUESTIONS

It would be helpful if any individuals responding could also identify whether they are GCC registrants or if not, whether they have direct experience of the GCC hearings process.

You can provide those details here

Name AUKC

Do you consider that the section headed "why are sanctions imposed" is sufficiently clear in its explanation of the GCC's over-arching objective?

Q1.

Yes

If no, please provide any suggestions for improvement in clarity.

Do you consider that the section on "the committee decision-making process" sets out the way in which decisions are to taken in different scenarios in enough detail for it to assist anyone reading the sanctions guidance to understand the process?

Q2.

Yes

If no, please comment on how this section of the document could be improved.

Do you think the section on "Conditions of Practice Orders" provides sufficient information about the circumstances in which conditions may be imposed, and about the process to be followed by the committee?

Q3.

Yes

If no, please comment on the areas that could be strengthened.

Is the introduction of a "bank" of conditions something you feel will help committees to impose consistent and workable conditions?

Q4.

Yes

If no, please explain why you think the bank of conditions will not assist with consistency and ensuring conditions are workable.

Is the additional information contained in the revised section about review hearings helpful in clarifying the different committees’ options at review hearings?
Q5

Yes

If no, please suggest further information it might be helpful to include.

Do you have any concerns about the wording of any of the specific template conditions with the proposed conditions bank? No

If so, please identify which condition(s) and the concern you have identified about it/them

Are there any additional conditions you think we should add to the proposed bank? No

If so please set out what conditions you consider would be useful

Do you have any further feedback in relation to the clarity of particular sections of the ISG or conditions bank?

If so please provide details here.
To: Members of Council  
From: Director of Education, Registration and Standards  
Subject: IR(MER)R Explanation Guide and procedures 2014  
Date: 21st March 2018

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Purpose

1. Council is asked to approve the withdrawal of the published Explanation Guide and Procedures documents on IR(MER), which relate to the Ionising Radiation (Medical Exposures) Regulations 2000. The Explanation Guide contains a summary of the legislation and outlines the requirements of the Regulations and the Procedures underpin the Guide with draft examples. Both documents can be found here: https://www.gcc-uk.org/publications/explanation-guide/

Background

2. The development of the IR(MER)R Explanation Guide and Procedures has a long and difficult history and resulted from the GCC’s dealings with the enforcement agencies for the Ionising Radiation (Medical Exposures) Regulations 2000 (IR(MER)). The Enforcement Agencies were the Health and Safety Executive (HSE), Health Protection Agency (HPA), the Care Quality Commission (and equivalents in Northern Ireland, Wales and Scotland). A summary of the activity since 2001 can be found in Appendix 1. Extracts from Council minutes can be found at Appendix 2.

Issues

3. It was clear to the Council in 2010 from meetings with the HSE Radiation Team that the GCC’s involvement was necessary to expedite progress in the public interest and for the protection of the public. The work was an attempt to clarify the legislation and ensure compliance in view of possible inspections.

4. The GCC has worked closely with the enforcement agencies over the years and has sought to circulate essential information on their behalf to GCC registrants and to facilitate engagement between enforcement agencies and the chiropractic professional organisations.

5. The issue of the ownership of any guidance on this subject published by the GCC has been raised at Council several times over the years yet the position of Public Health England (PHE) and Inspectorates had not been made clear to it. The Enforcement Agencies were unhappy when they discovered, after publication, in 2014 that the GCC documents referred to their agencies as endorsing the guidance and the GCC Council were not made aware of that issue at the time. Our experience shows that the enforcement agencies will not endorse guidance produced by others.

6. It is very much an anomaly for the GCC to produce guidance relating to legislation where we are not the enforcement body. We have not done that in other areas, for example, Data Protection and the General Data Protection Regulation.
7. The Explanation Guide and accompanying procedures are now out of date due to the new IRR17 and IR(ME)R 2018, which came into force on 6th February 2018. They therefore needs to be either withdrawn or updated.

8. The GCC has recently discussed the new regulations with the professional associations and the Royal College of Chiropractors. All those bodies have advised the GCC that they are making available some or all of the following advisory communications to chiropractors concerning the requirements: advice; guidance documents; audit toolkits; and training programmes.

9. Our understanding is that it is the minority of chiropractors who make referrals for x-ray exposures and take their own x rays (of the 524 registrant respondents to the GCC IR(ME)R Survey last year 189 take their own x rays).

10. The expertise in IR(ME)R lies with external organisations, both chiropractic and non-chiropractic such as the HSE and CQC. There would appear to be little value to be gained by the GCC investing its resources in producing an updated version of the Explanation Guides and Procedures, given that guidance is now available from the national enforcement agencies and that the various chiropractic professional bodies are also producing advisory communications and training materials on the topic.

Equality and diversity implications

11. None have been identified.

Financial implications

12. There are no resource implications for withdrawing the guidance. There would be considerable resource needed to revise the Explanation Guides and this work has not been included in this year’s Business Plan and budget. The GCC has no internal expertise in this field, and would essentially have to commission someone to do this work. Our understanding is that the chiropractic professional associations are calling upon the expertise of their medical physics experts in the production of their advisory communications and training materials.

Communications implications

13. The GCC would communicate with registrants about the removal of the out of date documents and signpost registrants to where they can access current information and training e.g. professional associations, the RCC, the CQC, HSE and the Royal College of Radiologists as well as advise how they can seek guidance from Radiation Protection Advisers / Medical Physics Experts.

Recommendation

14. The Executive recommends the withdrawal of the documents and to communicate this to registrants.
Appendix 1

1. In 2001 the GCC provided the enforcement agencies including the HSE for the Ionising Radiation (Medical Exposures) Regulations 2000 ([IR(ME)R] with a copy of the detailed IR(ME)R advice note it had published in 2000. This advice note was subsequently reissued in November 2004, the main change being that there is a more direct focus on the UK Regulations, rather than the original directive issued by the European Union.

These were drafted with the assistance of a Council member who was a Consultant Radiologist and with the input and agreement of Council.

Item 12  Updated Guidelines on Ionising Radiation (Medical Exposures) Regulations 2000 (tabled item)

Members NOTED that the work undertaken by Professor Iain McCall, GCC Lay Member, on updated guidelines for chiropractors on IR(ME)R 2000 continues.

Members were of the view that chiropractors must, for the protection of the public, understand the standards and protocols used widely within the NHS, particularly given the increased interaction between chiropractors and the providers of NHS radiology services.

It was AGREED that a systematic review of the legislation and its consequences for the profession should be investigated. Members appreciated the complexity of such a task and the Chairman invited suggestions as to who would be the most appropriate person or organisation to conduct the review.

GCC Council meeting minutes, June 2004

2. In September 2006 two of the enforcement agencies and the Health Protection Agency (HPA) requested a meeting with the GCC to discuss their concerns, with particular regard to employers’ written procedures, as follows:

“In summary, the Ionising Radiation (Medical Exposure) Regulations 2000 have been in place now for six years. While chiropractors may be acting in good faith and relying on the advice they have been offered, the situation regarding compliance with the Regulations, where it has been tested, is poor. The indications are this could well be widespread and cannot be allowed to continue. I am therefore writing to you, as the Regulatory Body for chiropractors, for support in progressing this matter with the appropriate professional bodies.”

3. While these were serious matters, the agencies offered the profession, via the professional associations, the opportunity to take control of the situation and secure the necessary improvements. In 2006 there was an attempt by the BCA and SCA to develop a checklist approach but this does not appear to have been completed.

4. In December 2009, at the request of the Inspector warranted by the Scottish Ministers for the IR(ME)R Regulations the GCC sent to all chiropractors in Scotland details of the inspection arrangements for IR(ME)R Enforcement in preparation for inspection visits.
5. In January 2010 the HSE Radiation Team requested a meeting with the GCC to discuss the following problems regarding compliance by chiropractors with the Ionising Radiation Regulations 1999:
   - Lack of understanding of the role of HSE and the powers of its inspectors;
   - Poor standards of training radiation protection;
   - Failure to designate radiation controlled areas; and
   - Poor quality assurance of x-ray equipment.

Section 4: Meeting with Health & Safety Executive Radiation Team. Members recognised the serious nature of the concerns raised by the HSE Radiation Team and agreed that they should be brought to the attention of chiropractic education providers as well as the profession. They welcomed the HSE’s offer to produce guidance for chiropractors on the identified issues, for distribution to the profession by the GCC.

GCC Council meeting, minutes, 17th February 2010

6. As is clear from the above, the enforcement agencies and the GCC had looked to the profession over a substantial period of time to make progress on the identified concerns.

7. In June 2010 the enforcement agencies requested a meeting with the GCC to discuss the issues that had emerged as a result of inspection visits to chiropractic practices with x-ray sets. They made clear that what they had found in respect of a range of compliance issues was not satisfactory, although they were still prepared to offer support in developing ‘industry specific’ guidelines in order to deal with this issue of public protection. Under the terms of the Memorandum of Understanding 2008 between the GCC and the Healthcare Commission (now CQC) it was agreed that the GCC would convene a Joint Technical Group, with appropriate representatives of education providers delivering approved courses, plus a representative of the Imaging Faculty of the College of Chiropractors.

8. In late 2010, two groups were set up and facilitated by the GCC to develop profession-specific guidance and template documents. Firstly, The Joint Technical Group was facilitated by Margaret Coats, former GCC Chief Executive and Registrar. This group requested that the profession produced industry specific guidelines, providing advice on the content and format. Secondly, the IR(ME)R Sub-group, facilitated by David Byfield, a Council member, subsequently met and agreed the draft documents.

9. The draft documents were reviewed and amended several times by the IR(ME)R sub group as per feedback from HPA (Health Protection Agency, now Public Health England) and CQC and the professional associations. The aim was to ensure that the HPA and IR(ME)R inspectors agreed with the documents, as it was understood that these would be the standard that they would use during any inspection.

10. The GCC finally published the two documents on a website in February 2014 along with an explanation of their development. We were immediately contacted by Public Health England (PHE) and the IR(ME)R Inspectorates and asked to remove the documents. The organisations expressed their disappointment at the lack of clarity regarding ownership of the documents. They said that from the outset of the project PHE and CQC had understood that their roles were simply to contribute to the GCC guidance. They stated that they had been clear that any publications would be under GCC, ownership and that they would be unable to endorse any such publication. They also said that they were also surprised to see the statement relating to their use during inspections. The GCC was informed that neither PHE nor any of the Inspectorates had seen a final draft of the guidance or supporting employer’s procedures. They therefore requested that these documents were removed from the GCC’s website until a draft had been made available with which they were all comfortable.
11. In April 2014 the GCC received comments from PHE on behalf of the IR(ME)R Inspectorates indicating they were generally happy with the documents. They stated that their involvement was simply to provide advice on a document that would remain under GCC ownership. They also requested, to avoid any confusion amongst registrants regarding the status of the documents, that the involvement in this project of PHE and the inspectorates should not be advertised. They said that they were unable to endorse the documents and left it to the GCC to decide how registrants should use the Explanation guide and example written procedures.

12. Council considered the PHE’s comments in June 2014 and agreed to publish the guidance, although it did not wish this to be called guidance, but rather Explanation Guides. Council agreed that the GCC should contact the Inspectorates to agree a form of wording to accompany the Explanation Guide and Procedures on the website explaining the background to the development of the documents. This was subsequently done and published. https://www.gcc-uk.org/publications/explanation-guide/

13. The GCC met with the CQC in 2016 after a long gap in contact in order to exchange information and the development of a new Information Sharing Agreement awaits finalisation by CQC.
Appendix 2
IRMER – Extracts from General Council Minutes 2010 - 2014

<table>
<thead>
<tr>
<th>Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-180810-17</td>
<td>Members noted that a joint IR(ME)R Technical Group has been formed, which will work collaboratively as the first step in developing a set of ‘industry specific’ guidelines for chiropractors.</td>
</tr>
<tr>
<td>C-020311-20</td>
<td><strong>Report: collaborative work with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Technical Group (oral report)</strong></td>
</tr>
<tr>
<td></td>
<td>The Chair reported that the IR(ME)R Inspectors wanted to make sure that employers’ responsibility was clear in this area. The burden of work has fallen on the appointed representatives from the education institutions and from the College of Chiropractors to progress work in this area.</td>
</tr>
<tr>
<td></td>
<td>David Byfield, one of whose staff was a member of the Technical Group, gave an update. Progress had been slow due to issues of time involved and resources, even though it was acknowledged by all partners that this was priority work and their commitment to it remained strong. The group needs to reconvene and refocus.</td>
</tr>
<tr>
<td></td>
<td>Members agreed that progress should be accelerated, but there was also a lack of clarity on the objectives for the work and GCC’s involvement in it.</td>
</tr>
<tr>
<td>C-210411-8</td>
<td><strong>IR(ME)R Technical Group</strong></td>
</tr>
<tr>
<td></td>
<td>Council noted that the enforcement agencies and the GCC have looked to the profession over a substantial period of time to make progress on identified concerns relating to compliance with IRMER. The GCC has repeatedly sought to facilitate progress.</td>
</tr>
<tr>
<td></td>
<td>Council was extremely concerned that the enforcement agencies continued to find problems with compliance by chiropractors with the relevant ionising radiation legislation, as required by the GCC’s Code and Standard and the law.</td>
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<td></td>
<td>Council AGREED that the GCC should continue to facilitate the work of the IR(ME)R Technical Group but cautioned against the GCC filling a vacuum by the publication of industry specific guidelines, which it considered would more appropriately be produced in partnership between the enforcement agencies and the profession.</td>
</tr>
<tr>
<td></td>
<td>Council members AGREED that chiropractic professional organisations (professional associations and College of Chiropractors) should be further involved, in particular, in the production of industry specific guidelines via GCC facilitation of an Imaging Standards Working Group Chaired by David Byfield.</td>
</tr>
</tbody>
</table>
### C-230911 – 33

**Any other business**

David Byfield reported that the IR(ME)R technical subgroup, which he had chaired, had met three times in recent months (4 April, 18 July and 12 September) to address technical issues related to x-ray standards. The last two meetings had included representatives of all the professional associations, along with educational providers and the College of Chiropractors.

These had been fruitful meetings which had produced standardised referral procedures.

Council agreed to convene a meeting of the full IR(ME)R group so that this issue could be progressed.

### C-260112 – 20

**Report from the IR(ME)R Technical Group (David Byfield) (oral)**

David Byfield reported that the meeting that had been planned for 22 December had been cancelled. However, there had been extensive comment and discussion on the documentation produced to date, particularly from Cliff Double of CQC, who had provided a great deal of feedback. The documents now needed to be edited to incorporate the changes.

DB suggested that all the required work on the documentation should be done by mid February and redistributed to the Technical Group for final approval. These documents could then be considered by Council in March or May, with recommendations for action by Council.

### C-290312 – 26

**IRMER Technical Group – oral update**

A member of the IRMER Technical Group gave an update on the progress thus far. Work has been undertaken regarding the referral criteria for x-rays, with comments received in February now circulated to Care Quality Commission and the Health Professionals Agency.

The Group intend to present the final report at the July 2012 meeting of Council.

### C – 030712 – 26

**IRMER Technical Group report**

A paper had been circulated on the developments on the IRMER work. The Group, chaired by David Byfield, was working to finalise profession-specific guidance, referral criteria and template documents required for compliance with ionising radiation legislation and regulations.

There was discussion about who would have ownership of these documents when they were published. The GCC had acted as facilitator but did not see itself as owners of the guidance.

### C – 200912 – 2

**Matters arising from minutes of meeting on 3 July 2012 and decision action log**

**Item 26 – IRMER Technical Support**

A member queried whether the issue of ownership of the report had yet been addressed. The CER responded that he was of the view that this item should not be "owned" by the GCC, but that no clarity had yet been
achieved on this point.

It was noted that the next Council at its meeting on 3 July 2012 had taken the view that while the GCC had acted as facilitator, it did not regard itself as the owner of the guidance. It was thought that the enforcement agencies such as the HSE and HPA might be the appropriate bodies to issue the guidance.

**Report from the IR(ME)R Technical Group**

David Byfield (DB) provided Council with the document that was produced following work that was carried out with HSE and HPA. The guidance was produced for chiropractors using radiographic imaging in their practices.

DB highlighted that ownership of the guidance was an issue that needed to be discussed by Council. He reiterated that there is the need to keep chiropractors in the loop and suggested that both documents should be uploaded on the GCC’s website.

Questions were raised with regards to ownership of this work and it was noted that it will be the responsibility of the office to carry on with this work after DB’s tenure on the Council expires. It was noted that the Council in previous discussions had made clear that it did not own the document as it was not within its statutory responsibilities to do so. While it could facilitate its dissemination through, for example, reference on the GCC website, it could not be seen as having responsibility for it.

**Report from the Chief Executive**

DH explained that he was still waiting for clarification from David Byfield, previous Chair of the IR(ME)R Working Group, regarding ownership of the guidance document on chiropractors using radiographic imaging in their practices following work that was carried out with the Health and Safety Executive and the Health Protection Agency. Once clarification of this was received and how it was to be badged, it would be disseminated to chiropractors. DH would update Council further on this matter at its June meeting.

**IR(ME)R Explanation Guide and Employer Procedures Item**

PB presented a paper to Council which explained the background to the development of the IR(ME)R Explanation Guide and Employer Procedures.

She explained that the Health Protection Agency, now known as Public Health England, and the Health and Safety Executive had endorsed the IRM(E)R documents and were expecting to be able to carry out inspections with the knowledge that chiropractors were aware of, and familiar with, the content of those documents.

PB suggested that Council should agree to upload the documents onto the GCC website. There was some concern that if the documents were placed on the GCC website, they would be viewed as something that was “owned” by the GCC. It was suggested that the documents should instead be placed on the Public Health England’s website. The view was also expressed that it was the duty of the GCC as a regulator to make these documents available in order to aid patient safety and that reliance should not be
placed on a third party. In addition to this, it was also noted that the Public Health England website contained a vast amount of information, and it was likely that if these documents were placed on that website, they would not be easily found by registrants.

Council members suggested that if it was agreed that these documents should be placed on the GCC website, their history and context should be included. It should also be made clear that the documents were not owned by the GCC but rather their production had been facilitated by the GCC.

The following was agreed by Council:
- The GCC would place the documents onto the GCC website;
- The documents would be referred to as ‘Explanation Guides’ and not as ‘guidance’ or ‘guidelines’;
- The GCC would explain that the documents, although placed on the GCC website, were not owned by the GCC;
- The Explanation Guide would include a statement of how it had been prepared and who had been involved in its preparation in addition to the information already given on the relevant enforcement agencies;
- The Explanation Guide would be made available in PDF format, whereas the procedures would be made available as a Word document to enable editing; and
- The GCC would seek to encourage the Professional Associations to disseminate the documents to their members.

It was stressed that the GCC should ensure that it was made aware of any future amendments made to the documents.

Council also agreed that David Byfield should be congratulated and thanked for his extensive involvement in the production of the IR(ME)R documents.

**ACTION:** The Executive to upload the IR(ME)R documents onto the GCC website according to the context required by Council.

**ACTION:** DH to write to David Byfield thanking and congratulating him for his involvement in the production of the IR(ME)R documents.

<table>
<thead>
<tr>
<th>C-030414-1 (Open)</th>
<th>Draft minutes of meeting of 3 February 2014 and matters arising IR(ME)R</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>An additional bullet point regarding agreed Council actions was included to read “The Explanation Guide would include a statement of how it had been prepared and who had been involved in its preparation in addition to the information already given on the relevant enforcement agencies.”</td>
</tr>
<tr>
<td>C-020614-2 (Closed)</td>
<td>IR(ME)R Explanation Guide</td>
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</tr>
<tr>
<td>In introducing this item the Chief Executive explained that as previously advised, the IR(ME)R Explanation Guide and procedures that had been placed on the GCC website had been removed.</td>
<td></td>
</tr>
<tr>
<td>The Director of Education explained that the paper on this item gave the background to the events since February 2014, and asked Council to agree the re-publication of the Guidance on the website.</td>
<td></td>
</tr>
<tr>
<td>She explained that the Inspectorates involved in this matter work with Regulators to facilitate publication of Guidance but that ownership of the Guidance remained with the regulator. Council agreed that the GCC should contact the Inspectorates to agree a form of wording to accompany the Guidance on the website explaining the background to the development of the Guidance.</td>
<td></td>
</tr>
</tbody>
</table>

**Action:** The GCC to consult with the Inspectorates to agree a form of wording to accompany the IR(ME)R guidance on the website.
Ionising Radiation (Medical Exposure) Regulations 2000 (as amended)
Ionising (Medical Exposure Regulations (Northern Ireland) 2000
(as amended)

(IR(ME)R)

An Explanation Guide for Chiropractors
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Appendix 1 – Statements for Radiation Protection File
Appendix 2 – Schedule 1 of IR (ME) R
Appendix 3 – Example of Protocols
Appendix 4 – Example of Exposure settings
Appendix 5 – Example Training Record
1. **Introduction**

The Ionising Radiation (Medical Exposure) Regulations 2000\(^2\) (as amended\(^2\,^3\)) and the Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2000\(^4\) (as amended\(^5\)) governs the use of ionising radiation, including radiographs, in healthcare. For the purpose of this document, these regulations will be referred as IR (ME) R. They apply to any facility that carries out medical exposures involving the use of ionising radiation, whether in the NHS or independent sector. This includes therefore any chiropractic practice that undertakes radiographic examinations.

The purpose of IR (ME) R is to minimize the risk to patients undergoing medical exposures. The legal requirements for the protection of employees who are involved in the use of ionising radiation are addressed by the Ionising Radiations Regulations (IRR 1999)\(^6\) and IRR (Northern Ireland) 2000\(^7\). These are not covered in this document.

The requirements of IR (ME) R apply regardless of the size of the chiropractic practice, number of chiropractors employed or number of radiographic exposures carried out, and the aim of this document is to assist chiropractic practices with their compliance with IR (ME) R through explanation and advice.

The use of ionising radiation within chiropractic practices falls largely into 3 categories:

1. Where only chiropractors undertake their own radiographs
2. Where, as well as chiropractors undertaking their own radiographs, other staff groups such as radiographers may take radiographs
3. Where chiropractors refer patients to local hospitals or nearby Chiropractic Practice, where there are radiography facilities.

These procedures and their appendices are intended as a guide only, and, whilst attempts have been made to ensure they are comprehensive, there will always be local variations which must be taken into account. Therefore, all the suggested text and examples must be carefully adapted to ensure they match local practice. Any text displayed in red will need to be carefully considered to demonstrate local ownership and practice.

It is important to note that, as definitive interpretation of law can only be established in the courts, the advice given here should be regarded as an expression of professional opinion rather than an absolute statement on the legal position.

Within IR (ME) R the term “medical exposure” is used to describe any exposure of an individual to ionising radiation but unless quoting directly from IR (ME) R the term chiropractic exposure will be used in this document.

IR (ME) R is regulated and enforced by different organisations within each of the four home nations. These are known within the regulations as the ‘appropriate authorities’.

England  
Care Quality Commission

Scotland  
The Scottish Ministers

Wales  
Healthcare Inspectorate Wales,

Northern Ireland  
The Regulation and Quality Improvement Authority
2. Duty Holders and their responsibilities

There are 4 classes of ‘duty holder’ defined within IR (ME) R, and the legal obligation associated with each role is detailed below. These responsibilities apply even when the same person is acting as the employer, referrer, practitioner and operator.

2.1 Employer

As defined within IR(ME)R Regulation 2, the employer is ‘any natural or legal person who, in the course of a trade, business or other undertaking, carries out (other than as an employee), or engages others to carry out, medical exposures or practical aspects, at a given radiological installation’.

The employer is sometimes known as the ‘legal person’. The employer as defined within IR (ME) R is not necessarily the same as that defined in employment law. It should be the most appropriate person to take the responsibilities of this role. The employer is required to provide a framework under which duty holders carry out their functions.

It may not be practicable for the employer to personally carry out all the duties required of the employer by IR (ME) R. While the task of carrying out these duties may be delegated to others, the legal responsibility will always remain with the employer. Therefore, any such delegation should be properly documented, along with arrangements by the employer to oversee implementation of these duties by the delegated person.

The duties of the employer are –

a) To ensure that appropriate written procedures are in place (Regulation 4(1)) and are subject to a quality assurance programme for document maintenance (Regulation 4(3) (b)). These written procedures shall include those defined in Schedule 1 of IR (ME) R, for example, procedures for entitlement of all duty holders, clinical evaluation and audit. A comprehensive list of Schedule 1 procedures may be found in Appendix 2. **Ensuring written procedures are in place is the most important duty of an employer.**

b) To ensure that the procedures are complied with by practitioners and operators (Regulation 4(1)(a))

c) To ensure that the training needs of practitioners and operators are met and that there is continuing education for these duty holders (Regulation 4(4)). See Section 4

d) To ensure there is an up to date training record for all practitioners and operators, including where the employer is concurrently the practitioner or operator (Regulation 11(4))

e) To establish recommendations on referral criteria for chiropractic exposures and make these available to all entitled referrers (Regulation 4(3) (a)). See Section 2.2

f) To ensure that appropriate written protocols are in place for every type of standard radiological practice and each piece of equipment (Regulation 4(2)). See Section 15

g) To establish diagnostic reference levels (DRLs) for standard radio-diagnostic examinations and ensure that there is a mechanism for assessment of compliance with these DRLs. If it is known that the DRLs are consistently exceeded, the employer shall set up a review and shall ensure that corrective action is taken (Regulation 4(3) (c) and (Regulation 4(6)). See Section 10

h) If research is carried out at the practice, to establish ‘dose constraints’ for biomedical and medical research programmes where there is no direct medical benefit to the individual (Regulation 4(3) (d)). See Section 7

i) To establish a process for the investigation of incidents resulting in exposures much greater than intended and for reporting such incidents to the appropriate authority (Regulation 4(5)). See Section 12

j) To ensure that a medical physics expert is retained and provides advice on matters relating to radiation protection concerning chiropractic exposures (Regulation 9(1)). See Section 2.4.1

k) To keep an inventory of equipment and ensure that this equipment is limited to the amount necessary (Regulation 10(1) and Regulation 10(3)). See Section 16
2.2 Referrer
A referrer is defined within IR (ME) R Regulation 2 as a **REGISTERED** healthcare professional who is entitled in accordance with the employer’s procedures to refer individuals to a practitioner for chiropractic exposure.

The referrer is responsible for supplying the practitioner with sufficient medical data (such as previous diagnostic information or medical information) relevant to the chiropractic exposure to enable the practitioner to decide on whether there is a sufficient net benefit (Regulation 5(5)). The referrer should take a history and perform a relevant assessment of the patient’s clinical information prior to requesting the radiograph, and document this information in the patient’s chiropractic records.

The referrer is expected to consider the specific ‘Referral Criteria’ provided by the employer when making a referral. Referral criteria should include the clinical problem or diagnosis, the type of radiograph required an indication of the radiation dose to the patient, and any additional relevant comments such as the recommended interval between radiographs. The referrer is usually a chiropractor, but potentially could also be an appropriate registered healthcare professional.

Where it is necessary for a chiropractor to refer a patient for a chiropractic exposure (such as a cervical or lumbar spine) that cannot be undertaken within the chiropractic practice itself, e.g. hospital radiology department or separate Chiropractic practice, then the chiropractor remains the referrer, but must be so entitled by the employer at the site where the exposure is undertaken.

It is for the employer where the radiograph is taken to ensure that all such ‘external’ referrers are properly entitled.

2.3 Practitioner
IR (ME) R Regulation 2 defines a practitioner as a **REGISTERED** healthcare professional who is entitled, in accordance with the employer’s procedures, to take responsibility for an individual chiropractic exposure. This is a different definition to that of a ‘chiropractic practitioner’ and care should be taken not to confuse the two.

Whilst the main duty of the IR (ME) R practitioner is the justification of individual medical exposures; the practitioner must also:

- **a)** Comply with the employer’s procedures (Regulation 5(1))
- **b)** Cooperate with the operator regarding practical aspects, with other specialists and staff involved in a chiropractic exposure, as appropriate (Regulation 5(6))
- **c)** Provide guidelines if they require entitled operators to authorise against them (Regulation 6(5)). See Section 5
- **d)** Ensure, to the extent of their involvement with the exposure, that the dose arising from the exposure is kept as low as reasonably practicable (Regulation 7(1))
- **e)** Only carry out a duty if they are trained to do so (Regulation 11(1))

Normally the role of the practitioner is carried out by a chiropractor.

2.4 Operator
Under IR(ME)R Regulation 2 an operator is ‘any person who is entitled, in accordance with the employer’s procedures, to carry out practical aspects of medical exposures, except where they do so as a trainee under the direct supervision of a person who is adequately trained’.

The operator’s duties are to take responsibility for each and every practical aspect which he/she undertakes. These duties may be carried out by a chiropractor or appropriate trained person involved in the process of taking a radiograph. Operators DO NOT need to be Registered Health professionals. Examples of practical aspects might be:

- Identification of the patient
- Carry out medical exposures
- Processing of radiographic film or CR plates
- Clinical evaluation of chiropractic exposures
○ Undertake QA of equipment

The range of duties for some operators may be fairly limited e.g. process radiographic film, but still must be specified. For this, it is recommended that employers establish a list of competences against which each operator may be entitled. (See Employer’s Procedure EP1 Appendix 2)

It is important to note that an X-ray Engineer is not entitled as an IR(ME)R Operator and simple performance/safety checks must be made on equipment AFTER a repair by IR(ME)R Operators employed by the practice before equipment is used on patients

Consideration should be given to the training requirements appropriate to each of the operator’s defined competences. (See Employer’s Procedure EP1 Appendix 1)

Whilst the primary role of the operator is to carry out the practical aspects of an exposure, an operator must also:

a) Comply with the employer’s procedures (Regulation 5(1))

b) Cooperate with the practitioner, regarding practical aspects, with other specialists and staff involved in a chiropractic exposure, as appropriate (Regulation 5(6))

c) Ensure, to the extent of their involvement with the exposure, that the dose to the patient arising from the exposure is kept as low as reasonably practicable (Regulation 7(1))

d) Only carry out a duty if they are trained to do so (Regulation 11(1))

2.4.1 Medical Physics Expert

The medical physics expert (MPE) should not be confused with the radiation protection adviser (RPA) which is identified in IRR99 and IRR (NI) 2000. The functions are different although, in practice, the same person may undertake both roles if suitably qualified.

The MPE must hold a science degree or its equivalent which is relevant to the use of ionising radiation as applied to chiropractic exposures. The MPE is required to have been adequately trained, for their involvement in chiropractic exposures under the Regulation 11(1) as this role is considered to be an operator function.

The MPE must be entitled by the employer as an operator, on appointment, and their roles and functions (their ‘scope of entitlement’ (SoE)) defined. Evidence of this appointment and definition of SoE might be included in the Radiation Protection File (see section 17).

Within a chiropractic practice, the MPE would be expected to undertake tasks such as giving advice on patient dose, development and use of new and/or complex techniques, as well as other matters related to radiation protection concerning medical exposures, when necessary (Regulation 9(2)(c)).

3. Entitlement

All referrers, practitioners, and operators (including MPEs) must be entitled by the employer, or by the person to whom the task of entitlement has been delegated. If the task of entitlement of duty holders is delegated, then the allocation of this duty should be clearly documented by the employer.

A prerequisite for entitlement as a referrer or practitioner within chiropractic practice is registration as a healthcare professional.

There is no requirement for operators to be registered. So, for example, an employer could, if they so wish, entitle an appropriately trained Receptionist or Practice Manager for the operator function of film processing.

Practitioners and operators must be adequately trained for the tasks they are entitled to perform (Regulation 11(1)), and the Regulations require that the employer shall keep an up-to-date record of such training which shall be available for inspection (Regulation 11(4)). More information on adequate training is covered in Section 4 of this guidance, and within Employer’s Written Procedures EP1.
The Regulations do not require that employers keep training records for their entitled referrers.

Each duty holder should have an associated scope of entitlement which outlines the duties they are entitled to undertake. This scope of entitlement might change over time for a number of reasons; a person might develop further skills, undertake additional training, or the practice might install new equipment. If the needs of a chiropractic practice change, then competences might need to be added or removed as appropriate.

### 3.1 Scope of entitlement

Entitlement as a practitioner or operator must be restricted to those functions for which the duty holder is properly trained and experienced. To achieve this, employers should define a set of ‘competences’ which are applicable for the various staff groups (registered chiropractors, radiographers etc.), then, for each staff member, assess and assign the appropriate range of duties according to training and competence.

Appropriate assessment of competence might include:

- **For referrers:** Competent to refer for all chiropractic exposures within the practice
- **For practitioners:** Competent to justify all chiropractic exposures within the practice
- **For operators:**
  - i. Competent to identify the patient prior to a chiropractic exposure in accordance with Employer’s Procedure EP4
  - ii. Competent to carry out all chiropractic exposures within the practice
  - iii. Competent for clinical evaluation of all chiropractic exposure carried out within the practice
  - iv. Competent to process films/CR plates
  - v. Competent to change chemicals in an x-ray processor
  - vi. Competent to carry out quality assurance on equipment

The employer may nominate specific individuals as competence assessors where it is impractical for them to personally assess all duty holders. A competence assessor should be entitled and experienced in the duties they are assessing.

For staff members that have been working within a practice for some time, and are known by the competence assessor to be competent to undertake certain duties, it is not expected that they be reassessed and asked to demonstrate competence. They may be deemed competent by their experience. A competence assessor may assess their own competence.

Each practice owner must also appoint a Medical Physics Expert, the scope of entitlement for whom should be to provide any necessary expert advice for all types of medical exposure carried out within the practice.

The provisions described above are reflected in the sample Employer’s Written Procedure EP1 and its appendices, which accompany this explanation guide. This also includes examples of required qualifications, training, and experience.

### 4. Training and Education

Under IR (ME)R Regulation 11(1), no operator or practitioner shall carry out a chiropractic exposure or any practical aspect without first having been adequately trained. Under IR (ME)R referrers do not need additional training on radiation protection, however there may be merit in having up to date training on new techniques and technologies relevant to chiropractic radiography. (Full IRMER Training is NOT legally required for Referrers but an awareness of the hazards of radiation is advised)

IR (ME) R also requires (Regulation 4(4) (a)) that the employer take steps to ensure that every practitioner or operator engaged by them is adequately trained to undertake all of their duties. This includes undertaking continuing education and training after qualification (Regulation 4(4) (b)). For example, in the case of clinical use of new techniques, this might include training related to these techniques and the relevant radiation protection requirements.

It is important that practitioners and operators maintain their competence for each duty for which they are entitled. If competence cannot be maintained for any reason, consideration should be given to either
undertaking further training or removing the task from their scope of entitlement. Where appropriate, a review of scope of entitlement could form part of an appraisal process.

The employer is responsible for ensuring an up to date record is kept of training and must make it available to an inspector if requested (Regulation 11(4)). The training record should contain, as a minimum, any relevant dates on which training was completed and the nature of the training. Whilst the employer is responsible for this record, it is often the duty holder themselves who maintains their own personal continuing professional development folder which contains a more detailed record. For clarity this could be laid out within an employer’s written procedure, though this is not required by the legislation. (See Employers Procedures, EP1) For an example of a training record, see Appendix 6.

When the employer is concurrently the practitioner and operator, he/she is required keep a record of their own training.

Regulation 11(5) says that when the employer enters into a contract with another employer to engage a practitioner or operator, the ‘supplying’ employer must provide the training records for each of these individuals to the chiropractic practice employer. E.g. in the case of an MPE, the MPE employer is responsible for keeping the MPE training records. This requirement should be specified in the contract between the employer and third party.

Where a duty holder is “in training” for a particular competence, that function may only be carried out under the supervision of a duty holder who is ‘assigned as competent’ for that function. The level of supervision shall be appropriate to the function in question, and the supervisor shall be responsible for carrying out that function in accordance with employer’s written procedures and protocols.

5. Justification and Authorisation

Justification is the intellectual process of weighing up the expected benefit of an exposure against the possible detriment of the associated radiation dose. Authorisation is the documentation that this justification has been carried out, and must occur prior to the exposure. This record is usually a signature or unique electronic entry either in the patient’s chiropractic notes against the referral for radiography, or on the referral form/letter.

Justification is the primary role of the practitioner. However, if it is not practicable for a practitioner to justify a chiropractic exposure, then an appropriately entitled operator may authorise an exposure using guidelines issued by a practitioner (Regulation 6(5)).

These are sometimes known as justification or authorisation guidelines. It should be noted that these guidelines are not required if chiropractic exposures are always justified and authorised by a practitioner.

These guidelines must be comprehensive and written by a chiropractor who is entitled as a practitioner for all the chiropractic exposures it contains. They should be explicit as to the age of patient they refer to e.g. adult or child. The guidelines must be verified by the practitioner to display ownership and demonstrate suitable document control.
When justifying an exposure appropriate weight must be given to the following:

<table>
<thead>
<tr>
<th>IR(ME)R - Regulation 6(2)</th>
<th>Consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>The specific objectives of the exposure</td>
</tr>
<tr>
<td>b</td>
<td>The characteristics of the individual involved</td>
</tr>
<tr>
<td>c</td>
<td>The potential diagnostic benefits to the individual from the exposure</td>
</tr>
<tr>
<td>d</td>
<td>The detriment the exposure may cause</td>
</tr>
<tr>
<td>e</td>
<td>The efficacy, benefits and risk of available alternative techniques having the same object but involving no or less exposure to radiation</td>
</tr>
</tbody>
</table>

IR(ME)R requires special attention to be given during the justification of any chiropractic exposure that is undertaken for either medico-legal reasons (Regulation 6(3)(a)) or for research when there is no direct benefit to the patient (Regulation 6(3)(b) and (c)).

Suggested chiropractic provisions for justification and authorisation have been outlined in Employer’s Written Procedure EP3.

6. Optimisation

Every chiropractic exposure must be optimised to ensure that the radiation dose arising from the exposure is kept as low as reasonably practicable (Regulation 7(1)). This is the responsibility of both the practitioner and operator in their respective roles.

Matters which may help ensure optimisation include the following; however this list is not exhaustive:

a) When purchasing new equipment or introducing new techniques, consideration should be given to the resultant dose to the patient
b) If using film, ensure that a fast film screen combination is utilised when applicable e.g. \( \geq 400 \) speed for spinal images
c) All practitioners and operators are adequately trained to perform the tasks for which they are entitled
d) Practitioners and operators undertake regular and relevant CPD and training after qualification
e) Protocols are written to ensure that the minimum number of exposures are taken to answer the clinical question
f) The correct settings are used to ensure that the dose is as low as reasonably practicable
g) The correct collimation used to ensure that the dose is as low as reasonably practicable
h) Images should be scored using the 1, 2, 3 system or poor, satisfactory, good system to monitor image quality. This may highlight any issues.
i) Audit of image quality
j) Implementing DRLs and preferably specific chiropractic DRLs where possible.
k) Quality assurance required by IR(ME)R 2000 and IRR99 aids optimisation

Critical examination of newly installed equipment, acceptance testing and regular equipment quality assurance is also ways to ensure that examinations are optimised; these are covered under IRR 1999 or IRR (NI) 2000.

IR (ME) R also calls for special attention for optimisation to be given to any medico-legal exposure (Regulation 7(7) a) and to exposures to children (Regulation 7(7) (b)). Although not defined in law, an example of special
attention may be having specific protocols in place for paediatric and medico-legal chiropractic exposures. X-rays on children should only be justified/authorised by Health Professionals and performed by Operators that have experience in this field. This should be considered before a Chiropractor justifies such exposures.

7. Research

Although not common within chiropractic practices, IR (ME) R places additional obligations relating to research exposures. These are listed below and, if research is undertaken within a chiropractic practice, must be addressed within the employer’s procedures. (See Employers Procedures EP12)

a) All research must have been approved by an ethics committee (Regulation 6(1)(c))
b) All individuals must participate voluntarily (Regulation 7(4)(a))
c) Individuals must be informed of the risks of the radiation exposure in advance (Regulation 7(4)(b))
d) Dose constraints must be set down in the employers procedures for individuals whom no direct medical benefit is expected (Regulation 7(4)(c))
e) Individual dose targets are planned when the individual is expected to receive a diagnostic benefit (Regulation 7(4)(d))

All X-ray images of the volunteer obtained during the research project MUST be reported and acted on as if they are non research Clinical images

A dose constraint is a restriction on the total dose of a research study that is not expected to be exceeded. The constraint is based on the total dose from all radio-diagnostic procedures included in the research protocol. A dose target is target level of dose set before research exposures begin, in this way, excessive doses should be avoided.

8. Medico-Legal

Medico-legal exposures are defined in Regulation 2 as an examination performed for insurance or legal purposes without a medical indication. An example of this may be a radiograph following an assault where compensation is being claimed and the radiograph is not required as part of the persons diagnosis or treatment.

IR (ME) R has additional obligations associated with medico-legal exposures which are listed below. If medico-legal exposures are undertaken within a chiropractic practice, an employer’s written procedure is required (See Employer’s Procedure EP13).

a) The practitioner when justifying the exposure shall pay special attention to medico legal exposures (Regulation 6(3)(a))
b) The practitioner and operator shall pay special attention to the need to keep doses arising from medico legal exposures as low as reasonably practicable. (Regulation 7(7)(a))

9. Diagnostic Reference Levels

Diagnostic Reference Levels (DRLs) are dose levels for typical examinations for standard sized patients that are not expected to be exceeded when good and normal technique is used (Schedule 1(g)).

The employer must establish DRLs (Regulation 4(3) (c)) and must undertake an appropriate review if they are consistently exceeded (Regulation 4(6)).

National and European DRLs (see for example Table 1 below) are available and should be considered when setting local values (Regulation 4(3) (c)). Local DRLs reflect local practice and could be calculated and provided to the employer by the MPE following a dose survey. Local DRLs set higher than the national ones would need to be explained. Further information on DRLs can be found on the Department of Health website.


<table>
<thead>
<tr>
<th>Radiograph</th>
<th>National DRL, ESD per radiograph (mGy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lumbar spine AP</td>
<td>14</td>
</tr>
</tbody>
</table>

DRLs, once established, should be made available and for awareness may be displayed next to the x-ray machine. It is considered good practice to have an understanding of the doses that result from local standard exposure factors. It must be noted that DRLs relate to mean doses for groups of patients and so apply to typical practice rather than individual exposures.

If a dose value, e.g. a ‘Dose Area Product (DAP), for a radiographic view, is displayed by the x-ray equipment, consideration of this information will give an indication of whether the corresponding local DRL has been exceeded.

Where the equipment does not provide a dose value after an exposure then regular quality assurance of the equipment should give reassurance that the intended exposure factors and dose are being delivered by the x-ray machine.

If a step-wedge test is carried out regularly and is within tolerance then it can be assumed that the x-ray machine and processor are both working correctly. If the step-wedge test is out of tolerance and the chemistry is proven to be correct, then consideration should be given to carrying out further tests on the x-ray equipment.

For CR/DR the resultant image may include a Sensitivity/Exposure Index or graph. This information can be compared the manufacturers recommendations which will give an indication of how much radiation has reached the detector. If the information displayed on the image is higher or lower than recommended, too much or too little radiation is being used. If no index/graph is displayed then care must be taken as the image will appear diagnostic even when too much radiation is used. If it can be demonstrated that a DRL has been unexpectedly exceeded, it should be documented along with any extenuating circumstances. Where DRLs are consistently exceeded it should be reported to the employer for investigation. Once an investigation has taken place any necessary corrective action must be implemented.

The procedure for establishing and using DRLs, along with the process of investigation needs to be documented (See Employer’s Procedure EP7).

10. Clinical Evaluation

Every exposure, including those taken as part of a clinical trial, must have a documented report or clinical evaluation. If it is known prior to the exposure that no clinical evaluation will occur, the exposure cannot be justified and cannot lawfully take place (IR (ME) R Notes for Guidance9 paragraph 9.10.1)

Clinical evaluation is considered to be one of the practical aspects of an exposure, and is therefore an operator function. The employer’s written procedures must make it clear where this evaluation is to be recorded e.g. in the patients chiropractic record, and how the entitled operator undertaking this task can be identified. (See Employer’s Procedure EP8)

In most cases the chiropractor will be the operator for clinical evaluation.
11. Incidents and near misses involving ionising radiation

It is a requirement of the legislation that when an employer knows or has reason to believe that the radiation dose given to a patient is ‘much greater than intended’ (MGTI), it must be investigated and if necessary be reported to the appropriate authority (Regulation 4(5)).

Incidents involving chiropractic radiation exposures can occur for several reasons. They may be due to an equipment fault, human error or a procedural failure. Incidents should be internally reported and investigated. Following a preliminary investigation, if it is found that a given exposure was MGTI then this would require external reporting to the appropriate authority. The MPE and RPA should be asked for advice prior to the reporting of any such incident. The authority will vary depending on the cause of the incident.

External reporting could be to either:

- The relevant national ‘appropriate authority’, for all incidents (see Section 1), excluding those due to equipment malfunctions. These include when the wrong patient is x-rayed or there has been a failure to follow Employer’s Written Procedures.
- HSE, for incidents caused by equipment malfunctions (IRR 99/IRR(NI) 2000)

“Near miss” incidents do not need to be reported, but, ideally, should be similarly investigated, as any lessons learnt can be applied and have the potential to prevent an actual incident from occurring. The process of investigation of incidents and near misses, including responsibilities and timescales may be laid out within employer’s written procedure, although this is not required under legislation. Then should a radiation incident occur the process of investigation will be standardised. (See Employer’s Procedure EP10) Further information can be obtained from either the Department of Health website or the Health and Safety executive Guidance document PM77 “Equipment used in medical exposure”.

12. Clinical Audit

Clinical audit is a requirement under IR (ME) R Regulation 8. It includes a review of chiropractic radiological practices which seeks to improve the quality and outcome of patient care. This can be done through a structured review which might lead to a modification of practice or the application of new practices where necessary. The employer’s written procedures should include provision for carrying out clinical audit as appropriate. (See Employer’s Procedure EP12)

Clinical audit might include:

a) Review of image quality monitoring (1, 2, 3 or poor, satisfactory, good). These should be reviewed to see if there are any issues which may highlight training requirements
b) Review of images, by multiple persons where possible, to agree levels of quality
c) Dose audit
d) An audit of chiropractic records to ensure that each chiropractic exposure has been referred, authorised, clinically evaluated and a written record made of the clinical evaluation in line with the written procedures and that the duty holders are identifiable
e) An audit to check that entitlement of staff has taken place and that it is supported by appropriate training and CPD when necessary
f) Audit of the patient identification process to ensure that each operator is following the correct procedure

13. Quality Assurance

Quality assurance (QA) as defined in IR (ME) R Regulation 2 refers to the provision and maintenance of the employer’s written procedures and protocols (see Employer’s Procedure EP11). It does not refer to equipment QA which is covered by IRR 99/IRR (NI) 2000.

Document QA entails ensuring that the employer’s written procedures and protocols comply with a document control system where the document author, version number, issue date, review date etc. are clearly identified, and that the documents are reviewed by the review date.
Schedule 1(e) requires that there shall be employer’s written procedures outlining what QA under IR (ME) R is to take place, who is responsible for carrying it out, how often documentation is reviewed, usually on an annual basis, and, importantly, how the employer knows this has taken place.

14. **Written Protocols**
The employer must ensure that written protocols are in place for every type of standard radiological practice for each piece of equipment (Regulation 4(2)).

Written protocols describe which exposures/projections should be done in most circumstances and should include matters such as whether it is an adult or paediatric exposure, routine and additional views, anatomy to be included on the image, +/- grid, +/- compensatory filtration, source to receptor distance, the machine settings or exposure factors, and the expected dose or DRL if available. Protocols may be displayed next to each x-ray machine. For an example of a written protocol and exposure chart see Appendix 4 and 5.

Written protocols are subject to the document quality assurance provisions referred to in Section 13 of this guidance (and see Employer’s Procedure EP11).

15. **Equipment**
The employer is responsible for keeping an up-to-date inventory of equipment and ensuring it is available to an IR(ME)R inspector if requested (Regulation 10(1)).

The inventory must contain the following information (Regulation 10(2))

a) Name of manufacturer  
b) Model number  
c) Serial number or other unique identifier  
d) Year of manufacturer  
e) Year of installation

The inventory must include all equipment that has the potential to impact patient dose e.g. processor, CR reader and each digital detector. It could also include information such as location and servicing arrangements if not covered elsewhere.

The employer must also ensure that the amount of equipment at an installation is limited to the amount necessary (Regulation 10(3)). This implies that any superseded equipment must be decommissioned.

16. **IR (ME) R within the existing Radiation Protection File**
Most chiropractic practices will already have a (paper or electronic) Radiation Protection File, and this could contain a number of statements which outline the key requirements of IR (ME) R (See Appendix 1).

These might include:

- Clarification over who is the IR(ME)R ‘employer’ for the organisation  
- Radiation doses to patients are kept as low as reasonably practicable consistent with the clinical purpose  
- Clear framework of delegation if persons are to carry out duties on the employers behalf (if appropriate)  
- That the required IR(ME)R procedures are in place  
- A statement that all duty holders must comply with IR(ME)R procedures  
- Appointment and entitlement of a Medical Physics Expert

This file should also include copies of the employer’s written procedures and protocols, and records to demonstrate that they have been read by the appropriate staff members.
17. References

1. Ionising Radiation (Medical Exposure) Regulations

2. Ionising Radiation (Medical Exposure) Regulations (Amendments)

3. Ionising Radiation (Medical Exposure) (Amendment) Regulations

4. Ionising Radiation (Medical Exposure) Regulations (NI)

5. Ionising Radiation (Medical Exposure) Regulations (NI) (Amendments) 2010
   http://www.opsi.gov.uk/sr/sr2010/plain/nisr_20100029_en_1

6. Ionising Radiation Regulations

7. Ionising Radiations Regulations (NI)

8. Ionising Radiation (Medical Exposure) (Amendment) Regulations (Northern Ireland)

9. Guidance on the establishment and use of “Diagnostic Reference Levels” (DRLs) as the term is applied in the
   Ionising Radiation (Medical Exposure) Regulations 2000

10. Guidance and good practice notes for IR (ME)
Appendix 1

The following statements describe some key requirements of IR (ME)R that could be considered for inclusion in the Radiation Protection File, if they are relevant and reflect local practice.

<table>
<thead>
<tr>
<th>IR(ME)R statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>For the XXXXX Practice, <em>(named person)</em> is the employer for the purposes of IR(ME)R.</td>
</tr>
<tr>
<td>The employer will ensure that all of the Employer’s Written Procedures and protocols required for compliance with IR(ME)R are provided and are authorised by <em>(named person)</em> on behalf of the employer, and are subject to a written procedure for document quality control.</td>
</tr>
<tr>
<td>Entitlement of duty holders at XXXXX Chiropractic Practice, will be carried out by <em>(named person)</em>, on behalf of the employer <em>(if a different person)</em>.</td>
</tr>
<tr>
<td>The employer will ensure that all referrers to the XXXXX Chiropractic Practice are provided with appropriate referral criteria.</td>
</tr>
<tr>
<td>Responsibility for the task of maintaining a record of training of duty holders under IR(ME)R (including other staff carrying out procedures within the chiropractic practice’s premises) will lie with <em>(named person)</em>.</td>
</tr>
<tr>
<td>A Medical Physics Expert shall be appointed and entitled to be involved as required for consultation on optimisation, including patient dosimetry and quality assurance, and to give advice on matters relating to radiation protection concerning chiropractic exposures.</td>
</tr>
<tr>
<td>The employer shall establish ‘diagnostic reference levels’ (DRLs) for chiropractic examinations and ensure that there is a mechanism for assessment of compliance with these DRLs. Where it is known that DRLs are consistently exceeded, the employer shall set up a review, and shall ensure the corrective action is taken.</td>
</tr>
<tr>
<td>The employer shall establish a procedure for the investigation of incidents which may have resulted in an overexposure of patients and for reporting such incidents to the appropriate authority for IR(ME)R and HSE or for incidents due to equipment malfunction the HSE (for IRR 99)/MHRA.</td>
</tr>
<tr>
<td>Entitled practitioners and operators must comply with the employer’s procedures. For the avoidance of doubt, where a person acts as employer, referrer, practitioner and operator concurrently (or in any combination of these roles) he shall comply with all the duties placed on employers, referrers, practitioners or operators under these Regulations accordingly.</td>
</tr>
<tr>
<td>All practitioners and operators, to the extent of their respective involvement in a chiropractic exposure, shall ensure that doses arising from the exposure are kept as low as reasonably practicable consistent with the intended purpose.</td>
</tr>
<tr>
<td>Responsibility for maintaining an inventory of all radiation equipment used at the XXXXX Chiropractic Practice lies with <em>(named person)</em>.</td>
</tr>
<tr>
<td>The document authoriser is responsible for ensuring that the document is reviewed within the required period and for recording completion of each review (irrespective of whether the document is amended or not).</td>
</tr>
</tbody>
</table>
Appendix 2

IR (ME) R Schedule 1

The whole of Schedule 1 is included below for completeness. However Procedure (f) ‘...and administered activity’ and all of Procedure (i) refers to nuclear medicine examinations so are not applicable to chiropractic exposures.

Schedule 1

The written procedures for medical exposures shall include –

a) procedures to identify correctly the individual to be exposed to ionising radiation;
b) procedures to identify individuals entitled to act as referrer or practitioner or operator;
c) procedures to be observed in the case of medico-legal exposures;
d) procedures for making enquiries of females of childbearing age to establish whether the individual is or may be pregnant or breastfeeding;
e) procedures to ensure that quality assurance programmes are followed;
f) procedures for the assessment of patient dose and administered activity;
g) procedures for the use of diagnostic reference levels established by the employer for radiodiagnostic examinations falling within regulation 3(a), (b), (c) and (e), specifying that these are expected not to be exceeded for standard procedures when good and normal practice regarding diagnostic and technical performance is applied;
h) procedures for determining whether the practitioner or operator is required to effect one or more of the matters set out in regulation 7(4) including criteria on how to effect those matters and in particular procedures for the use of dose constraints established by the employer for biomedical and medical research programmes falling within regulation 3(d) where no direct medical benefit for the individual is expected from the exposure;
i) procedures for the giving of information and written instructions as referred to in regulation 7(5); (applies to use of radioactive materials only)
j) procedures for the carrying out and recording of an evaluation for each chiropractic exposure including, where appropriate, factors relevant to patient dose;
   procedures to ensure that the probability and magnitude of accidental or unintended doses to patients from radiological practices are reduced so far as reasonably practicable.
## Appendix 3 Example of Chiropractic Written Protocols

<table>
<thead>
<tr>
<th>PRO1</th>
<th>Example Protocols for chiropractic radiographs</th>
<th>XXXXX Practice</th>
</tr>
</thead>
</table>

### Cervical Spine (Adult)

<table>
<thead>
<tr>
<th>Routine Views</th>
<th>SID cms</th>
<th>GRID</th>
<th>Collimation to visualise</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>AP</td>
<td>100</td>
<td>yes</td>
<td>C3 –T2 Soft tissue of neck laterally</td>
<td></td>
</tr>
<tr>
<td>APOM</td>
<td>100</td>
<td>yes</td>
<td>C1 and C2 Mandibular- rami laterally</td>
<td></td>
</tr>
<tr>
<td>LATERAL</td>
<td>180</td>
<td>yes</td>
<td>Sella- tursica - superior border T1 All spinous processes and anterior soft tissue</td>
<td>Compensatory filter may be used if patient unable to depress shoulders, exposure to be adjusted appropriately</td>
</tr>
</tbody>
</table>

### Additional Views

| Swimmers      | 180     | yes  | To include part of Cervical spine not visualised on lateral view. |          |
| Oblique       | 180     | yes  | C1 – T1 Soft tissue of neck | To assess IVF |
Appendix 5 – Example of Chiropractic Exposure Settings

<table>
<thead>
<tr>
<th>PRO2</th>
<th>Example Exposure Settings for chiropractic radiographs</th>
<th>XXXXX Practice</th>
</tr>
</thead>
</table>

The information within the columns with red headings may not be available for all types of exposure or machine. They are all shown here for demonstration purposes to provide examples of the type of information that may be available.

This protocol information may be displayed in a different format and limited to the exposure settings available.

**Adult Exposures for film**

<table>
<thead>
<tr>
<th>Examination</th>
<th>Source To Receptor distance</th>
<th>kV</th>
<th>mAs</th>
<th>mA</th>
<th>sec</th>
<th>Local DRLs</th>
<th>Specific comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>AP cervical spine</td>
<td></td>
<td>100</td>
<td>75</td>
<td>4.8</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lat cervical spine</td>
<td></td>
<td>180</td>
<td>80</td>
<td>10.5</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AP knee</td>
<td></td>
<td>100</td>
<td>60</td>
<td>5</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lat knee</td>
<td></td>
<td>100</td>
<td>60</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The information within the columns with red headings may not be available for all types of exposure or machine. They are all shown here for demonstration purposes to provide examples of the type of information that may be available.

Factors for differing sizes of patients must be included.

This protocol information may be displayed in a different format and limited to the exposure settings available.

Exposure protocols specifically for children must be included if paediatric radiographs are taken at a Chiropractic practice.
Appendix 6
Examples of Training records

<table>
<thead>
<tr>
<th>Name</th>
<th>Job title</th>
<th>Site/Room/Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>e.g. chiropractor, chiropractic assistant, etc.</td>
<td>e.g. XXXX Practice, Exam room 2, X-ray machine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task</th>
<th>Trainer initials</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switch x-ray equipment on and off</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Aware of exposure charts and protocols</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can select appropriate exposure factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undertake an exposure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use collimation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete room log including exposure factors/dose when appropriate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This person has received training on the above tasks  

| Signature of trainer | |
| Name of Trainer | |
| Signature of duty holder | |

---

<table>
<thead>
<tr>
<th>Name</th>
<th>Job title</th>
<th>Site/Room/Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>e.g. chiropractor, chiropractic assistant, etc.</td>
<td>e.g. XXXX Practice, Exam room 2, Desktop processor</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task</th>
<th>Trainer initials</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switch x-ray equipment on and off</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Process a film</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clean processor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change chemicals in processor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Processor QA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This person has received training on the above tasks  

| Signature of trainer | |
| Name of Trainer | |
| Signature of duty holder | |

---

<table>
<thead>
<tr>
<th>Name</th>
<th>Job title</th>
<th>Site/Room/Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>e.g. Chiropractor, chiropractic assistant, etc.</td>
<td>e.g. XXXXX Practice, Exam room 2, X-ray machine + desktop processor</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task</th>
<th>Trainer initials</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of x-ray machines</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>How to process a film</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This person has received training on the above tasks  

| Signature of trainer | |
| Name of Trainer | |
| Signature of duty holder | |
**Chiropractic IR(ME)R Procedures**

**For Practices where chiropractors undertake their own chiropractic radiographic images**

It is intended that these procedures are to be read in conjunction with the associated document, IR(ME)R, an Explanation Guide for Chiropractors. The Procedures must only be regarded as draft examples. The explanation guide contains a summary of the legislation and outlines the requirements of the Regulations.

All the suggested text and examples must be carefully adapted to be specific to each individual clinic and ensure they match local practice. Any text displayed in red will need to be carefully considered to demonstrate local ownership and practice. The most successful way to write IR(ME)R procedures is to think about what happens within the practice and start by writing down ‘what you do’. Procedures should standardise practice and ensure that all chiropractic staff are working to the same standards.

In this document the terms referrer, operator and practitioner are designated persons as defined under the IR(ME)R Regulations and no other definition.
**XXXX Practice Employer’s Procedures**

Written Procedures for Chiropractic Exposures

<table>
<thead>
<tr>
<th>Author</th>
<th>Named person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version No.</td>
<td>1</td>
</tr>
<tr>
<td>Authorised by</td>
<td>Signature of Employer</td>
</tr>
<tr>
<td>Implementation Date</td>
<td>01/01/2013</td>
</tr>
<tr>
<td>Reviewer</td>
<td>Named Person</td>
</tr>
<tr>
<td>Next Review Date</td>
<td>01/01/2016</td>
</tr>
</tbody>
</table>
## IR(ME)R Employer’s procedures

<table>
<thead>
<tr>
<th>Document No.</th>
<th>Title of Procedure</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>EP1</td>
<td>Entitlement of Duty Holders</td>
<td>4</td>
</tr>
<tr>
<td>EP2</td>
<td>Referrals for chiropractic examinations</td>
<td>9</td>
</tr>
<tr>
<td>EP3</td>
<td>Justification and Authorisation</td>
<td>11</td>
</tr>
<tr>
<td>EP4</td>
<td>Patient Identification</td>
<td>13</td>
</tr>
<tr>
<td>EP5</td>
<td>Pregnancy Enquiries</td>
<td>15</td>
</tr>
<tr>
<td>EP6</td>
<td>Assessment of Patient Dose</td>
<td>17</td>
</tr>
<tr>
<td>EP7</td>
<td>Diagnostic Reference Levels</td>
<td>18</td>
</tr>
<tr>
<td>EP8</td>
<td>Clinical Evaluation</td>
<td>19</td>
</tr>
<tr>
<td>EP9</td>
<td>Training and Education</td>
<td>20</td>
</tr>
<tr>
<td>EP10</td>
<td>Reducing the Probability and Magnitude of unintentional exposures (inc. incident investigation)</td>
<td>22</td>
</tr>
<tr>
<td>EP11</td>
<td>Document Quality assurance</td>
<td>23</td>
</tr>
<tr>
<td>EP12</td>
<td>Audit</td>
<td>26</td>
</tr>
<tr>
<td>EP13</td>
<td>Research Exposures</td>
<td>27</td>
</tr>
<tr>
<td>EP14</td>
<td>Medico-Legal Exposures</td>
<td>28</td>
</tr>
</tbody>
</table>
1. Objectives

- To outline the method for entitling individuals as duty holders under IR(ME)R
- To ensure that each duty holder has appropriate registration, qualifications, experience and training (as appropriate) for their entitlement
- To clarify who holds the training records for each duty holder

2. Responsibilities

(named person, employer or job title) will entitle duty holders and ensure that structures are in place to maintain records of agreed qualifications, experience and training required for individuals to perform the roles of duty holders for all types of chiropractic exposures (Appendix 1).

(named person, employer or job title) will agree the range of tasks to be included in the competence document for staff under their management, which is appropriate and supported by verifiable training and experience, and this will define the duty holder’s scope of practice. (For Chiropractic Practices with multiple sites, it may be appropriate for the Lead Person at each site to assess their staff’s competence and then provide this information to the employer or named person for entitlement).

Each Duty Holder is responsible for maintaining their own personal training record containing their evidence of training and continuing professional development. The employer is legally required to keep up to date records of Training Practitioners and operators must comply with the employer’s procedures.

3. The process of entitlement

Entitlement is demonstrated by (named person or employer) (the Entitler) signing an individual’s competence document (Appendix 2) on behalf of the employer. The Entitler must decide whether the evidence presented is sufficient for each individual to be entitled in the role of practitioner, operator, and/or referrer for X-ray exposures. Duty holders themselves also must have agreed and signed this document. If this is the same person it will only be signed once as the Entitler. The agreed competence for each individual will create their own scope of entitlement which they must adhere to.

(named person, employer or job title) will agree the range of tasks to be included in the competence document for staff under their management, which is appropriate and supported by verifiable training and experience, and this will define the duty holder’s scope of practice. (For Chiropractic Practices with multiple sites, it may be appropriate for the Lead Person at each site to assess their staff’s competence and then provide this information to the employer or named person for entitlement).

The competence document will evolve and be updated as an individual’s scope of entitlement changes without the need to be resigned by the Entitler.

Competence will be assessed for each practitioner and operator by an appropriately trained person. A Competence assessor may assess their own competence.

The Medical Physics Expert (MPE) will be entitled on appointment. They should only be appointed if they are adequately trained for this specific role.

Entitlements should be reviewed on an annual basis by a named person, employer or job title
### Appendices:

#### Appendix 1

**Agreed qualifications, experience and training required for individuals to perform each duty holder role**

<table>
<thead>
<tr>
<th>Registrant Group</th>
<th>IR(ME)R Duty Holder</th>
<th>Qualifications/Training/Experience required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractor</td>
<td>Referrer</td>
<td>Registration with GCC</td>
</tr>
<tr>
<td></td>
<td>Practitioner</td>
<td>Registration with GCC</td>
</tr>
<tr>
<td></td>
<td>Operator</td>
<td>Registration with GCC</td>
</tr>
<tr>
<td></td>
<td>Operator</td>
<td><strong>Appropriate local training/radiography training/qualification</strong></td>
</tr>
<tr>
<td>Medical Physics Expert</td>
<td>Operator</td>
<td>Science degree or equivalent Experience in the application of physics, within chiropractic use of ionising radiation HCPC Registration Clear appointment to this role</td>
</tr>
<tr>
<td>Medical Physicist/Technologists</td>
<td>Operator</td>
<td><strong>Appropriate qualification</strong></td>
</tr>
</tbody>
</table>
## Appendix 2

**Example Tasks for entitlement as a Duty Holder under IR(ME)R at XXXXX Practice**

<table>
<thead>
<tr>
<th>Name of Duty Holder</th>
<th>Job Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Qualification(s) and date obtained</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Registration Number</th>
<th>Date last checked</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Training records held by</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Referrer tasks at XXXXX Practice

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Assigned as competent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Date &amp; signature/initials of duty holder and assessor</td>
</tr>
<tr>
<td>Refer for all chiropractic examinations excluding fluoroscopy</td>
<td></td>
</tr>
<tr>
<td>Refer for fluoroscopic examinations</td>
<td></td>
</tr>
</tbody>
</table>

### Practitioner tasks at XXXXX Practice

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Assigned as competent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Date &amp; signature/initials of duty holder and assessor</td>
</tr>
<tr>
<td>Competent to justify requests for all chiropractic examinations excluding fluoroscopy</td>
<td></td>
</tr>
<tr>
<td>Competent to justify requests for fluoroscopic examinations</td>
<td></td>
</tr>
<tr>
<td>Operator tasks at XXXXX Practice</td>
<td>Assigned as competent</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td></td>
<td>Date &amp; signature/initials of duty holder and assessor</td>
</tr>
<tr>
<td>Competent to carry out patient identification</td>
<td></td>
</tr>
<tr>
<td>Competent to authorise all chiropractic exposures for which guidelines have been provided by a practitioner</td>
<td></td>
</tr>
<tr>
<td>Competent to undertake all chiropractic examinations excluding fluoroscopy</td>
<td></td>
</tr>
<tr>
<td>Competent to undertake fluoroscopic examinations</td>
<td></td>
</tr>
<tr>
<td>Competent to process x-ray films</td>
<td></td>
</tr>
<tr>
<td>Competent to change chemicals in a x-ray processor</td>
<td></td>
</tr>
<tr>
<td>Competent to process CR plates</td>
<td></td>
</tr>
<tr>
<td>Competent to process a digital image</td>
<td></td>
</tr>
<tr>
<td>Competent to clinically evaluate all chiropractic examinations undertaken at the practice</td>
<td></td>
</tr>
<tr>
<td>Competent to clinically evaluate all chiropractic examinations undertaken elsewhere</td>
<td></td>
</tr>
<tr>
<td>Competent to make pregnancy enquiries</td>
<td></td>
</tr>
<tr>
<td>Competent to carry out quality assurance on equipment</td>
<td></td>
</tr>
</tbody>
</table>

Entitled by

Name of Entitler

Signature of Duty Holder (DH)

IR(ME)R procedures read by DH
1. **Objectives**

- To outline how a referral may be made for a chiropractic exposure
- To ensure that the referrer provides sufficient information for the patient and the referrer to be identified and sufficient clinical information for the exposure to be justified and authorised by a practitioner or authorised by an operator

2. **Responsibilities**

The employer must ensure that Referrers are GCC Registered Chiropractors or other Registered Health Professionals.

The employer shall establish recommendations concerning referral criteria for chiropractic radiographs/fluoroscopy and shall ensure that these are available to the referrer. These should include an indication of the typical effective dose to the patient for each type of radiographic examination.

The referrer shall supply the practitioner with sufficient medical data (such as previous diagnostic information or medical records) relevant to the chiropractic exposure to enable the practitioner to decide on whether there is sufficient net benefit for the exposure to be justified.

3. **The Process of referral**

A clinical assessment of every patient’s anatomy should be performed prior to requesting any radiographs.

3.1 **When the referrer is also the practitioner and operator**

Where the referrer also acts as the practitioner and operator for a chiropractic exposure, he/she must ensure that the request for the radiograph/fluoroscopy is documented within the patient’s chiropractic record/notes. Within this entry the clinical indications for the radiograph should be clear, fit with the referral criteria, and the referrer must be identifiable by signing/initalling the referral.

3.2 **Referring to a different operator**

If a different entitled operator is to carry out the chiropractic exposure then a request card/referral form/letter/note must be completed legibly by the referrer and be available before the chiropractic exposure can be carried out.

The essential information required on each request card/referral form/letter is listed below.

- Patients full name, date of birth and address
- Chiropractic radiographic examination requested
- Sufficient clinical information relevant to the chiropractic exposure requested
- Signature of referrer
- Name of Referrer (Printed) (must be a GCC Registered Chiropractor or Registered health professional)
- Date of referral
- Patient contact telephone number (if relevant and available)

3.3 **Referring to another chiropractic practice or hospital**

If a referral to carry out the chiropractic exposure is made to an external site then a request card/referral form/letter must be completed legibly by the referrer in line with the external sites procedures.
3.4 Accepting referrals from another chiropractic practice
The following essential information is required on each request card/referral form/letter:

- Patients full name, date of birth and address
- Chiropractic radiographic examination requested
- Sufficient clinical information relevant to the chiropractic exposure requested
- Signature of referrer
- Name of referrer (Printed) (must be a GCC Registered Chiropractor or Registered health professional)
- Date of referral
- Patient contact telephone number (if relevant and available)

3.5 Incomplete referrals
Any referral to another practitioner or operator found to be incomplete shall be returned to the referrer and the examination shall not be undertaken until all essential information has been entered.

4. Referral criteria
Copies of the referral criteria document used at this Practice, (such as the recommended Chiropractic Radiology referral guidelines), are made available to the referrers in each room/personal copy.
1. **Objectives**
   - To ensure that every chiropractic exposure is justified and authorised

2. **Responsibilities**

   It is the responsibility of the practitioner to justify each individual chiropractic exposure taking the following into account:

   - the specific objectives of the exposure and the characteristics of the individual involved
   - the total potential diagnostic benefits, including the direct health benefits to the individual and the benefits to society, of the exposure
   - the individual detriment that the exposure may cause
   - the efficacy, benefits and risk of available alternative techniques having the same objective but involving no or less exposure to ionising radiation

   Operators cannot undertake justification. However, in the absence of an entitled practitioner, authorisation may be undertaken by a properly entitled operator, in accordance with **signed** written guidelines provided by a practitioner. The responsibility for justification remains with the practitioner who has provided the guidelines, but the operator is responsible for the proper interpretation of these guidelines.

   If the practitioner/operator is aware, at the time of authorisation, that a recorded clinical evaluation shall not result from the exposure, then the exposure must not be authorised and cannot take place.

3. **The Process for justification and authorisation**

   **3.1 When the referrer is also the practitioner and operator**

   If the chiropractor is acting as entitled referrer, IR(ME)R practitioner and operator, the referrer’s **signature/electronic personal code** in the clinical notes next to the request for an x-ray will demonstrate authorisation of the exposure.

   **3.2 When the referrer is also the practitioner but not an operator**

   If the referrer is also acting as the IR(ME)R practitioner, then the **request card/referral form/letter/electronic record** provided to the operator must also be authorised to demonstrate that justification for the exposure has been carried out. Authorisation for the exposure is taken to be the **signature, initials or electronic personal code** in the patient’s chiropractic notes against the referral for radiography, or on the **referral card/form/letter/electronic record**
3.3 When the referrer is not the practitioner
If the referrer is entitled as a referrer but not practitioner then the request for a chiropractic radiographic exposure must be either:

a) Justified and authorised by an entitled practitioner
   The practitioner must initial or sign the referral (state where on the referral or electronic record) to demonstrate authorisation if they are satisfied that the exposure is authorised or;

b) Authorised by an entitled operator using guidelines
   Entitled operators may undertake authorisation using specific guidelines set out and signed by a Practitioner. Entitled operators must check the clinical details against the appropriate guideline and, if the details match a criterion, the operator initials or signs the referral (state where on the referral or electronic record) to designate that the chiropractic exposure has been authorised.

   Referrals which do not fall within the guidelines issued by the practitioner cannot be authorised by an operator and must be referred to a practitioner for justification.

4. Special attention for justification
Special attention for justification is required for the justification of the following types of exposure

   a) exposures on medico-legal grounds
   b) exposures that have no direct benefit for the individuals undergoing the exposure e.g. research
   c) exposures to children.
1. Objectives

To ensure that each authorised chiropractic exposure is delivered by the entitled operator to the intended patient.

2. Responsibilities

The operator who undertakes the exposure is responsible for ensuring that the correct patient receives the correct examination.

3. The Process for patient identification

The operator who undertakes the exposure is responsible for ensuring that the correct patient receives the correct examination. A clinical assessment of every patient’s anatomy should be performed prior to undertaking any radiograph. The operator undertaking the exposure can then be confident that the correct patient is receiving the correct radiographic examination.

3.1 When the patient is already in the consulting room

When the patient is already in the consulting room it is not practical, or suggested, that they should be asked to formally identify themselves again.

When a patient is called into the consulting room their identity should be confirmed prior to the chiropractic examination starting using the method outlined in 3.2. If an operator, other than the chiropractor, e.g. receptionist carries out an initial identification ID MUST BE CONFIRMED AGAIN by the chiropractor prior to the clinical examination starting.

If the referrer, practitioner and operator are the same person, then the operator might be confident that they have the correct patient for the correct radiograph but this should confirmed and written confirmation of this made.

The signature/initials of the operator undertaking the exposure must be recorded on the referral (state where on the referral) or by another method e.g. electronic.

3.2 When the operator undertaking the exposure is not the referrer

When a patient is called from a waiting area or room by an entitled operator who was not the referrer, the following identification process MUST BE CARRIED OUT.

Where possible, the operator must ask the patient to give the 3 identifiers. The procedure must be positive and active i.e.

“What is your name?”
“What is your address?”
“What is your date of birth?”

If the patient is deaf these questions can be asked using written cards.
On completion of this the operator must verify that this patient identification procedure has taken place by entering their name/ signature/initials on the referral form (state where on the referral) or by another method e.g. electronic to enable the operator to be identified.

If a paediatric patient is too young to be able to identify themselves, their parent or guardian should be asked all 3 identification questions on behalf of the child.

If the patient through illness, physical or mental disability, or language barrier is not able to confirm his/her identity:

- Always treat them with dignity and respect
- A carer or relative may be asked to identify the patient if they are escorted
- Examine any personal photographic identification they may have such as a passport or photographic driving licence
- For patients with language difficulties, the operator may identify the patient through an interpreter if one is available
- When possible, the referrer may be asked to confirm the identity of the patient

When the patient is unable to identify themselves the method used to confirm patient identity should be recorded (state where). The operator must verify the patient identification procedure as above adding which method of identification was used.

If there is any doubt about the patient's identification, the operator must not carry out the chiropractic exposure.

2. Differences between patient identifiers

If one aspect of the patient identifiers does not correspond between the referral and the information obtained, but the operator is sure it is the correct patient, e.g. one digit different in date of birth or different address (old address), then the operator may use their professional judgement and the details may be changed. Clerical staff should be informed of the change to allow this to be changed on the patient’s chiropractic record.
1. **Objective**

To prevent unnecessary exposure of a foetus from a medical exposure.

2. **Responsibilities**

The justifying Practitioner shall take account of the patient’s pregnancy status in deciding whether to authorize or to delay the medical exposure.

The Operator who initiates the exposure shall re-check pregnancy status with the patient and shall record the result of this enquiry in accordance with this Procedure.

The Medical Physics Expert shall, when requested by the Practitioner, assist the Practitioner in risk assessments, dose calculations and appropriate techniques to minimize the dose to the foetus.

3. **Practical Procedure**

   3.1 **Referral process**

The Referrer must provide the Practitioner with sufficient clinical information to enable him/her to justify any examination. The Referrer shall therefore:

   - Record in the request if the patient is known to be pregnant, or might be pregnant, at the time of the referral.

   3.2 **Justification process**

In justifying any exposure the Practitioner shall:

   - Take account of any information supplied by the Referrer.
   - Consider whether any other procedure not involving ionising radiation would be more appropriate.
   - Make the decision to justify the exposure if this is appropriate. The decision may be taken in consultation with the Referrer but the decision to justify the exposure remains the Practitioner’s responsibility. When a decision is made by the Practitioner to justify an exposure of a patient who is or may be pregnant, a record of the decision must be made in the patient’s records.

   3.3 **Immediately prior to radiation exposure**

Immediately prior to any radiation exposure, the Operator undertaking the exposure shall determine whether the patient is, or could be, pregnant.

The Operator shall ask the Patient the following questions:

1. “Is there any possibility that you may be pregnant?”
2. “What is the date of the first day of your last period?” (LMP)
If the patient is certain of not being pregnant she shall then be asked to complete a pregnancy status form. If pregnancy cannot be excluded the Operator should use the LMP and enforce the 10 day/28 day rule. On completion of this the operator must verify that this patient pregnancy enquiry procedure has taken place by entering their name/ signature/initials on the referral form (state where on the referral) or by another method e.g. electronic to enable them to be identified. Consideration should be given to delaying any exposure if it is not urgent until the patient is sure of her pregnancy status if there is any doubt.

3.4 Girls aged 12 to 15 years

All young people who can give valid consent, (i.e. with decision making capacity), have a fundamental legal and ethical right to determine what happens to their own bodies. Consequently the Operator should normally make enquiries on pregnancy status for girls of child-bearing potential between the ages of 12 and 15 years in private, with the parents not present if possible.1

(A procedure must be in place should any girl under 15 years is/could be pregnant)

3.5 Limitations of pregnancy testing

Due to the potential of high rate false negatives during early pregnancy, the use of pregnancy testing kits should not be considered as conclusive evidence that a patient is not pregnant.

Reference

1. Gillick Competency and Fraser Guidelines
   http://www.nspcc.org.uk/inform/research/questions/gillick_wda61289.html
1. The process for recording factors relevant to dose

All operators initiating a chiropractic exposure should adhere to the pre-set settings, if available, based on body part thickness, unless further optimisation is possible or necessary. All exposures should be recorded in the radiography log book. This includes body part thickness, kV, mAs and source to receptor distance. (DAP meter readings should be recorded if these are available) These, along with the total number of exposures must be recorded within the radiographic log book by the operator that undertook the exposure. This will include the reason for carrying out any repeat exposures. In addition, the reasons for significantly exceeding any DRLs should be recorded (see EP7).

The operator undertaking the exposure will be aware of the range of doses or Diagnostic Reference Levels (DRLs) that result from the exposure factors set within the protocols.

The employer will implement a programme for carrying out patient dose surveys in consultation with the MPE to ensure compliance with local and National DRLs.
1. The process of establishing Diagnostic Reference Levels (DRLs)

DRLs provide standard values of dose that are derived from a dose audit. They are typical values for typical examinations of average size patients.

- The DRLs will be set by the employer in consultation with the Medical Physics Expert, as laid out within their contract/based on recent national dose surveys and will be subject to an audit every 3 years
- Current DRLs will be made available by the relevant x-ray machine/in the Radiation Protection File
- Once set, these DRLs are not expected to be exceeded (for average patients) when good and normal practice regarding diagnostic and technical performance is applied

2. Using DRLs

The operator undertaking the exposure, when possible, must ensure that after each exposure any dose information is considered in relation to the DRL.

2.1 Dose information available

If following each exposure, the x-ray machine provides a DAP value or some other dose indicator this should be reviewed by the operator with regard to the appropriate DRL.

If the DRL is exceeded it should be recorded along with any extenuating circumstances in designated book / electronic record. If the DRL is found to be consistently exceeded the reasons must be investigated immediately. The operator must inform (the employer/line Manager/RPS/MPE) as soon as they are aware that the DRL is being consistently exceeded.

2.2 No dose value available

If following each exposure, the x-ray machine does not provide a DAP value or other dose indicator, it is not possible to consider the dose with regard to the DRL. However there are some reassurances that the intended dose has been given depending on the image acquisition method.

   a) CR or DR images

   The resultant image includes a Sensitivity/Exposure Index or graph. This will be compared the manufacturers recommendations. If the value/graph is unexpectedly outside the recommended range then the RPS/lead chiropractor will be informed and further tests may be made.

   b) Film

   The amount of radiation reaching the film may be assessed by evaluating the image quality. If the chemistry is known to be correct and the film is too dark, then it may be that too much radiation is being emitted and therefore the DRL may be exceeded. The RPS will be informed and further tests may be made if necessary.

3. Reviewing DRLs that are consistently exceeded

The MPE, RPS or operator must inform the employer as soon as they are aware that the DRL is being consistently exceeded.

If the DRL is believed to be consistently exceeded (either as identified by the MPE, operator or RPS) the reasons must be investigated immediately by the employer/named person/MPE so that corrective action may be taken.

Any corrective action should be documented and communicated to relevant staff.
1. The Process of recording a clinical evaluation

Following a chiropractic exposure each image must be clinically evaluated by an operator so entitled, usually a chiropractor, and the findings documented in the patient’s record/electronic record/notes.

This evaluation of the whole image shall include:

- The identity, signature or initials of the operator undertaking the evaluation
- The details of all findings including
  - Findings relevant to the patients management or prognosis
  - No abnormality detected.

2. Clinical evaluation of radiographs taken on patients from other practices

All external referrers who also act as operators for the clinical evaluation of images undertaken at xxxx Practice will be entitled for this role by named person/job title/employer. As such, they are responsible for ensuring that a competent clinical evaluation will be made and recorded on all images returned to them from this practice. XXXX Practise can take no responsibility for the competence of the clinical evaluation of these images; however we retain the right to include a check on whether these images are being properly evaluated in our clinical audit programme under the Regulations.
1. **Objectives**

- To ensure all entitled practitioners and operators have received adequate training for the duties they are entitled for, and that records of such training are maintained and reviewed
- To ensure that entitled practitioners and operators undertake continuing professional education and training after qualification including, in the case of clinical use of new techniques, training related to these techniques and the relevant radiation protection requirements

2. **Responsibilities**

The employer will ensure that arrangements are in place to maintain an up to date list of qualifications and duties for each duty holder (see EP1 Appendix 2).

The employer is responsible for ensuring that the training records are reviewed on an annual basis and that this review is used to confirm a duty holder’s scope of entitlement.

Practitioners and operators shall satisfy themselves that they have appropriate training and experience to undertake duties that they are entitled to perform, and shall maintain a personal portfolio of their education, training, experience and competence. They must not carry out any duty for which they have not been trained and entitled.

3. **Process**

The employer MUST maintain an up-to-date record of qualifications, training, and tasks for each entitled practitioner and operator. This also includes documentation of local equipment training, procedures and protocols.

Each duty holder is responsible for maintaining their own personal training record containing their evidence of training and continuing professional development.

Each duty holder’s personal portfolio should demonstrate the nature of any training and the date on which training was completed. The employer is legally required to keep up to date records of Training.

**Annual appraisals** will ensure that ongoing relevant professional education is undertaken for each duty holder by the duty holder’s line manager. Each duty holder should provide their own personal training records for this appraisal to ensure that a maintained competence for each duty holder role can be demonstrated.

(named person, employer or job role) must check the registration for all referrers and practitioners on an annual basis. A record of such registration and the date checked is held within the individual’s competence document.

On induction and with the implementation of any new radiation equipment or equipment software, there must be associated training by appropriate staff such as experienced Chiropractors or an application specialist when new equipment is installed. This training will be documented within the duty holder’s training record. Their scope of practice should be assessed by a competence assessor.
Practitioners and operators shall satisfy themselves that they have appropriate training and experience to undertake duties that they are entitled to perform. They must not carry out any duty for which they have not been trained and entitled.

Where the employer enters into a contract with another to engage a practitioner or operator (e.g. agency staff or MPE), the latter (e.g. MPE) shall be responsible for keeping their training records. All records need to be made available if required.

Any students or other trainees may undertake any aspect of the duty for which they are being trained provided if this is done under the supervision of a person who is themselves adequately trained and entitled for that duty.

This is expected to be ‘direct’ supervision and the supervisor shall take responsibility for the activity as if they had carried it out themselves.
1. Process
The XXXXX Practice will reduce the risk of unintentional exposures by adopting the following:

- Employers procedures and protocols will be in place and regularly reviewed to ensure they match local practice.
- All equipment will regularly undergo quality assurance to ensure it is functioning correctly.
- Additional equipment QA checks carried out if over 5% of images are deemed unacceptable.
- Staff feedback given following incidents.
- Training and competence assessments will be undertaken including when new equipment and procedures are introduced.
  - Induction programmes for new staff.
  - Grading and review of chiropractic images.
  - Clinical audit.
  - Audit of procedures.
  - Good practice and technique applied.
  - Investigation of near miss incidents.
  - Peer review of images – looking at image quality to include positioning, collimation, density, sharpness and exposure.

All duty holders will comply with the employer’s procedures.

Practitioners and operators will cooperate to ensure that the doses arising from an exposure are kept as low as reasonably practicable consistent with the intended purpose.

The XXXXX Practice will also reduce the risk of unintended exposures by investigating all near miss and actual incidents using following procedure.

2. Internal incident and near miss reporting
If it is suspected that an unintended patient exposure, overexposure or near miss has occurred, the individual who discovered the error shall record the following information on an incident form/other method of recording and provide it to the employer/RPS immediately.

- The age and demographic details of the patient.
- The x-ray machine settings, the kV and mAs and dose area product (DAP) (if known).
- Any other relevant information e.g. error codes, time for which the exposure appeared to continue, or unusual signals.
- What happened and why.
- Any other relevant information.

If it is suspected that the incident is due to an equipment malfunction, named person, employer or job title must ensure the equipment is withdrawn from use and other staff notified. Warning signs should be placed on the faulty equipment. The equipment must not be reused until the reason for the incident has been clarified. Call the equipment service engineer or RPA for assistance if necessary.

3. Internal incident and near miss investigation
Named person or the employer shall assemble evidence to determine what events lead to the near miss or incident and to allow the dose to be calculated in consultation with the MPE or RPA. The report from this investigation shall include details of what happened and why, the dose assessment, whether the patient has been informed, what actions have been taken to minimise the risk of a similar incident occurring in the future and any other recommendations.
If advised that the incident is reportable by the MPE or RPA, the \(\text{Name}\) person or employer or MPE/RPA will inform the relevant authority.

Regulations require that incidents involving a exposure of a patient to a radiation dose ‘much greater than intended’ are reported to:

- the Health and Safety Executive (HSE) if they are due to an equipment fault (IRR99/IRR(NI) 2000)

- or the CQC/HIW/RQIA/Scottish ministers if they result from an error or procedural failure (IR(ME)R) in cases of medical exposures in chiropractic imaging.

See the HSE and DH website or consult your RPA or MPE, for information on what constitutes much greater than intended.

4. Records and learning

\(\text{Name}\) person, employer or job title shall place copies of the incident report in the Radiation Protection file and the patient’s chiropractic/electronic records. This report shall be retained for at least 2 years if it was not much greater than intended. If the incident was reportable to the CQC/HIW/RQIA Scottish ministers a record must be kept for at least 10 years. For incidents reported to HSE a record must be kept for at least 50 years.

Any lessons arising or changes to practice following the investigation will be implemented to ensure that the risk is minimised in the future. Relevant staff will be informed of all incidents, any lessons arising from the investigation and any changes to practice by e-mail, staff meeting or handover book.
1. Objectives
   - To ensure appropriate document control for all IR(ME)R documents

2. Responsibilities

The employer will ensure that the Employer’s Written Procedures and Employer’s Written Protocols are reviewed **every 3 years** or sooner if practice changes or new equipment is installed. These will have unique numbers, for Employer’s Written Procedures EP1 etc., and for Employer’s Written Protocols PRO1 etc.

If a procedure or protocol changes it is the responsibility of the Authoriser to inform all relevant staff.

The author of a document is responsible for the content whilst the Authoriser is responsible for ensuring the document is in place.

3. Document control

Each document shall be uniquely identified.

3.1 Employer’s procedures will display the following front page

<table>
<thead>
<tr>
<th>XXXXX Practice Employers Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written Procedures for Medical Exposures</td>
</tr>
<tr>
<td>Author</td>
</tr>
<tr>
<td>Version Number</td>
</tr>
<tr>
<td>Authorised by</td>
</tr>
<tr>
<td>Issue Date</td>
</tr>
<tr>
<td>Reviewer</td>
</tr>
<tr>
<td>Review Date</td>
</tr>
</tbody>
</table>

Each individual procedure will display a **Header** e.g.

<table>
<thead>
<tr>
<th>EP 1</th>
<th>Entitlement of Duty Holders</th>
<th>XXXXX Practice</th>
</tr>
</thead>
</table>

Each individual procedure will also display a **Footer** e.g.
3.2 Written protocols and other IR(ME)R documents

These will display a header and footer, examples given below.

Header

| PRO1 | Protocols for radiographs | XXXXX Practice |

Footer

| Issue Date: | Version No. | Authorised by | Author | Review date: | Page 2 of 4 |

3.3 Document holding and control

Named person, employer or job title, will review and update when necessary all procedures at least once every 3 years or when new equipment/change in procedural organisation requires changes to practice.

All employer’s written procedures and written protocols shall be available to all practice staff and contained in the radiation file.

All duty holders must comply fully with employer’s written procedures, and appropriately with written protocols (allowing appropriate latitude for professional judgement), so each employee is responsible for ensuring that they are working to the current version of these procedures and protocols (which may be printed for convenience).
1. **Process**

The employer will ensure that an audit program is in place to outline the methods to be used to carry out each audit. The audit program will describe the person responsible for carrying out each of the audits, the standards, criteria, timescales and details of the audit process.

The audit programs can be found in the audit file/electronic folder.

The employer will feed back the results of the audits to the relevant staff.

The **following ANNUAL** audits shall be undertaken at XXXX Practice (amend as appropriate):

1. Assurance that all procedures and protocols are within date and will be reviewed by the review date
2. An audit to ensure all procedures and protocols are actually being followed
3. An audit of duty holders’ entitlement along with their supporting qualifications and training. This audit should ensure that their entitlement matches the duties performed and that it is supported with evidence of training and continuing professional development
4. An audit of referrals to ensure that they have been made according to EP2 and that a clinical evaluation has been carried out in line with EP8. This will ensure that the referrer, practitioner and operator(s) for each exposure can be identified
5. An audit of referrals to ensure that they have been justified and authorised in line with EP3 and that the practitioner can be identified
6. An audit to ensure that the patients are identified in line with EP4 and the operator can be identified
7. An audit of patient dose should be undertaken three yearly by the MPE.
8. An audit of operator compliance with EP6, should also be undertaken
9. An overview of all near miss and incidents reported in the last 12 months including outcomes
10. Review of image quality and repeat exposures
11. An audit to ensure that research exposures have been taken in line with EP13
12. An audit to ensure that medico-legal exposures have been taken in line with EP14
No research exposures are currently undertaken at XXXX Practice

In which case please delete the rest of EP13

1. Process

Research Exposures are only permitted in accordance with prior written approval from the National Ethical Committee obtained via submission of an application, in conjunction with the MPE, through the ‘Integrated Research Application System’ (IRAS) (http://www.myresearchproject.org.uk).

The employer will ensure that systems are in place to inform any practitioner and operator who might be involved in an exposure, that patients may be part of a research study when they are referred for imaging. This will be communicated by e-mail/staff meeting/ handover book.

It is the responsibility of the individual practitioner for a research study to ensure that every request is justified. Special attention is required for the justification of exposures that have no direct benefit for the individuals undergoing the exposure.

A protocol for each research project will be written by the research practitioner and be made available to all operators in the research folder/ electronically.

The Practitioner shall ensure that operators are aware that a request is part of a research study.

• Operators must follow the research protocol specifically developed for the research study ensuring that the number of X-ray exposures of a particular type of X-ray on a particular participant will not be exceeded by a further X-ray exposure

• Operators must report to named person/their line manager any instances where exposures are being made for research purposes where this has not been clearly indicated on the request or if they suspect that the study has not been approved

• The clinical evaluation must be performed by an appropriately entitled operator, and reported through appropriate communication arrangements

2. Patient consent

All potential participants must receive a written explanation of the research programme and its risks and have the opportunity to discuss these with a responsible person before agreeing to take part. The explanation must make clear that treatment will not be prejudiced by failure to take part.

All individuals taking part in a research programme do so voluntarily. Each participant will sign a statement indicating that the whole procedure has been properly explained, that they voluntarily undertake the procedure and are aware of the risks including those from the radiation exposure.
No medico-legal or occupational health exposures are undertaken at XXXX Practice

In which case please delete the rest of EP14

1. Process
Medico-legal referrals are those examinations performed for insurance or legal purposes of any kind without a medical indication, for example:

- Assessment of accidental injury for legal or insurance purposes
- Assessment of non-accidental injury

Please delete or add any other types of medico-legal exposure here

Referrals for medico-legal examinations must be clearly identified and must be justified by a chiropractor.

No person shall carry out a medico-legal exposure unless it complies with the employer’s procedure for such exposures

The radiographic history of each patient attending for medico-legal or occupational health surveillance examinations should be checked by the chiropractor and recent similar examinations should be taken into account. For instance it may not be necessary to complete a whole series of radiographs if some have been taken recently.
To: General Chiropractic Council  
From: Paul Ghuman, Deputy Chief Executive  
Subject: Annual Report and Accounts  
Date: 21 March 2018

Purpose

1. Council is asked to note the timetable for the preparation of the annual report and annual accounts for 2018.

Background

2. The annual report and accounts was agreed by Council at its meeting in June 2017 last year. We are anticipating that this year’s annual report and accounts will be considered by Council in June 2018.

Issues Arising

3. The draft annual report 2017 will be prepared in a similar format to the annual report 2016.

4. At the June Council meeting the Council may wish to make recommendations to the executive about changing the format of the annual report in future years, to focus on different/additional aspects of the organisation’s performance and/or to include more forward-looking information.

5. The Council’s annual accounts are now being prepared under a new accounting standard called FRS102. In order to ensure compliance with the standard, it is a requirement that the auditors review the annual report alongside the annual accounts to ensure that both reports present a true and fair view of the performance in the previous year.

Progress to date

6. Last year, Council has agreed that the 2016 Annual Report must be prepared by April 2017. The intended timetable for the 2017 Annual Report and the 2017 Annual accounts is shown below:
Annual accounts preparation timetable

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 January 2018</td>
<td>Planning meeting with auditors</td>
<td>Completed</td>
</tr>
<tr>
<td>22 February 2018</td>
<td>Audit plans presented to Audit Committee by external auditor</td>
<td>Completed</td>
</tr>
<tr>
<td>29 March 2018</td>
<td>Draft accounts provided to auditors</td>
<td>Pending</td>
</tr>
<tr>
<td>3 April 2018</td>
<td>External audit takes place this week</td>
<td>Pending</td>
</tr>
<tr>
<td>TBC</td>
<td>Completion meeting with auditors</td>
<td>Pending</td>
</tr>
<tr>
<td>31 May 2018</td>
<td>Auditors attend audit committee meeting to present all the audit findings</td>
<td>Pending</td>
</tr>
<tr>
<td>27 June 2018</td>
<td>Statutory accounts to be signed of by Council. Auditors in attendance.</td>
<td>Pending</td>
</tr>
</tbody>
</table>

Annual report preparation timetable

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 March 2018</td>
<td>First draft of the non-financial elements of the annual report prepared by CER</td>
<td>Pending</td>
</tr>
<tr>
<td>18 April 2018</td>
<td>Consolidated first draft report prepared by the DCE and made available to the auditors</td>
<td>Pending</td>
</tr>
<tr>
<td>2 May 2018</td>
<td>Final draft agreed following input from the Chair of Council and made available to the auditors</td>
<td>Pending</td>
</tr>
<tr>
<td>31 May 2018</td>
<td>Auditors attend the meeting of the Audit Committee when the Committee consider the draft reports</td>
<td>Pending</td>
</tr>
<tr>
<td>W/C 10 April 2018</td>
<td>Annual Report and accounts to be signed of by Council. Auditors in attendance</td>
<td>Pending</td>
</tr>
</tbody>
</table>

Proposals

7. Council is asked to note the timetable for the preparation of the annual report and the annual accounts.

Implications

<table>
<thead>
<tr>
<th>Financial</th>
<th>The annual report and annual accounts are printed on annual basis and these costs are included within the current budget. There are therefore no other financial implications.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>The requirement on the GCC is to lay the annual report and accounts in Parliament within 12 months of the year-end. This will be achieved and therefore there is no risk implication.</td>
</tr>
<tr>
<td>Legal</td>
<td>There are no legal implications</td>
</tr>
<tr>
<td>Communication</td>
<td>Both the annual report and the annual accounts are to be placed on the GCC website once completed. Both documents will also be sent to relevant stakeholders who request a copy.</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>There are no equality and diversity implications</td>
</tr>
</tbody>
</table>
To: The Council, General Chiropractic Council
From: Jamie Button
Subject: Annual registrations report 2017
Date: March 2018

Purpose
1. The purpose of this paper is to present to Council the Annual registrations report covering 2017, attached at Annex A.

Background
2. A paper covering the previous registration year is published annually to provide a resource going forward of the work undertaken by the registrations team during the period.

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

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

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

Communications implications
6. The report will be published on the GCC’s website and the profession and stakeholders will be notified through the newsletter.

Action
7. Council is asked to note the report.
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<td>New registrants</td>
<td>6</td>
</tr>
<tr>
<td><strong>Routes to registration</strong></td>
<td>8</td>
</tr>
<tr>
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<td>8</td>
</tr>
<tr>
<td>2 – applicants holding relevant foreign chiropractic qualifications</td>
<td>10</td>
</tr>
<tr>
<td>Test of Competence</td>
<td>12</td>
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<td>3 – applicants applying under EU General Directive 2005/36/EU</td>
<td>19</td>
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<td>4 – Temporary and Occasional registration</td>
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<td>20</td>
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<td>Survey of new registrants</td>
<td>21</td>
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<td><strong>Removals from the register</strong></td>
<td>28</td>
</tr>
<tr>
<td><strong>Diversity of registrants</strong></td>
<td>31</td>
</tr>
<tr>
<td><strong>Communications</strong></td>
<td>34</td>
</tr>
</tbody>
</table>
Report on the 2017 registration year

This report provides an overview of the work undertaken by the registrations team of the General Chiropractic Council (GCC) between from 1 January to 31 December 2017.

The Register

The Register of Chiropractors opened in 1999 and since over 4,500 chiropractors have been registered. As of 31 December 2017, 3,220 chiropractors were on the register, with 2,956 having paid the practising fee and 263 the non-practising fee. In addition one was registered on a temporary and occasional basis.

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

What this tells us

There has been a steady increase in the total number of registrants since 2007, with 780 more at the end of 2017 than 2007 and therefore on average the Register is growing at around 78 registrants each year.

Figure 2 – accumulative percentage increase in registrant numbers since 31 December 2007
What this tells us
The accumulative percentage increase on the 31 December 2007 figure of 2,440 is 32%. As chiropractic is a relatively small profession in the UK there is further scope for growth and we should expect increases in the future size of the profession. Further consideration is given to potential future trends on page 20 of this report.

Figure 3 – percentage increase in registrant numbers since 31 December 2007

What this tells us
While the population of the register increases year on year, the percentage growth has fluctuated between 1.3% and 4.4% since 2013. At the end of 2016 there was a marked reduction in the growth of the Register, dropping to 1.3%, but which has now recovered slightly to 2.2%, helped by the higher number of applicants in 2017. This can be partly explained by the continued reduction in the number of registrants paying the non-practising rate, which is considered further from page 22 of this report.

Figure 4 – percentage increase in practising registrants

What this tells us
There has been a reduction in the increase of practising registrants since 2015, however it still remains higher than the overall increase in registration numbers of 2.2%. Given that
numbers of UK graduates does has not significantly increased over the past five years. The fact that the number of new registrants annually remains relatively static, while the register grows, means that the percentage increase will naturally slow over time. However, the figure will vary by a few percentage points per annum and it is worth continuing to keep a record of this figure to note any variables.

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

What this tells us
14 fewer registrants paid the non-practising fee for 2018 than for 2017, representing the fewest registrants paying the non-practising rate since at least 2012. This is important to note as it is practising registrants in the UK who represent the greatest risk to public protection. The 2015 retention period produced a significant increase in registrants paying the non-practising rate; following this guidance setting out the GCC’s view of when it is appropriate for registrants to pay the lower fee was published. Since then the number of those registrants’ paying the lower rate has decreased by 58.

Further consideration is given to the reasons given for paying the non-practising rate on page 26.
New Registrants during 2017
An overview of 2017 new registrants

195 chiropractors joined the Register in 2017, 29 more than in 2018 when 166 were registered. The monthly split of new registrants was as follows:

Table 1 – number of new registrants by month from 2013 to 2017

<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>2017</td>
<td>13</td>
<td>8</td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>47</td>
<td>47</td>
<td>31</td>
<td>4</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>2016</td>
<td>7</td>
<td>11</td>
<td>8</td>
<td>6</td>
<td>2</td>
<td>5</td>
<td>46</td>
<td>33</td>
<td>17</td>
<td>7</td>
<td>23</td>
<td>1</td>
</tr>
<tr>
<td>2015</td>
<td>20</td>
<td>18</td>
<td>6</td>
<td>9</td>
<td>5</td>
<td>4</td>
<td>34</td>
<td>30</td>
<td>24</td>
<td>7</td>
<td>23</td>
<td>7</td>
</tr>
<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 where peaks in initial registration applications occur during the year.

Figure 6 – number of new registrants by month during from 2013 to 2017

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

In the 2015 and 2016 registration reports we reported spikes in registrations during November, this dropped in 2017 to 13 new registrants. However, the figure for December 2017 rose to 11, and so registrations over those two months were move evenly spread.
Table 2 - 2017 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>170</td>
</tr>
<tr>
<td>Route 2 – Foreign qualified</td>
<td>21</td>
</tr>
<tr>
<td>Route 3 – EU General Directive</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>195</strong></td>
</tr>
</tbody>
</table>

What this tells us

In total 170 UK graduates registered in 2017 making up the largest proportion of new registrants. In addition, 21 applicants registered on the basis of holding a foreign chiropractic qualification and having passing the Test of Competence. The remaining 4 applicants hold EU community rights and previously practised elsewhere in the European Economic Area (EEA). The numbers applying with overseas qualifications remains relatively static, largely due to the upper constraints on the numbers able to sit the Test of Competence and the small numbers applying through the EU General Directive.
Routes to GCC registration

The route an applicant takes to registration depends primarily on their chiropractic qualification. Nationality is also taken into consideration where European law applies.

Route 1 – recognised qualification from an accredited course (UK)

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

Route 2 – unrecognised overseas chiropractic qualification (Test of Competence)

Applicants must have a chiropractic qualification from outside the UK that meets the requirements of our rules and also demonstrate they meet our educational standards by passing the Test of Competence.

Route 3 – EU General Directive (establishment)

Applicants must possess EU community rights and have practised, or be registered to practise, in another EEA member state.

Route 4 – EU General Directive (temporary and occasional)

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

Applicants holding UK recognised qualifications (route 1)

The GCC currently accredits courses from three UK educational institutions, and accreditation of a fourth programme is progressing. Only graduates from accredited colleges are eligible to apply for registration, on the basis that they hold a qualification recognised for the purposes of registration.

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

The following table gives the numbers of 2017 graduates from accredited courses registered before 1 March 2018.
Table 3 – new registrants by institution

<table>
<thead>
<tr>
<th>Educational institution</th>
<th>Month course completed</th>
<th>Number of graduates</th>
<th>Number registered</th>
<th>% of graduates registered during 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>McTimoney College of Chiropractic (MCC)</td>
<td>October/December 2016(^1)</td>
<td>32</td>
<td>28</td>
<td>88%</td>
</tr>
<tr>
<td>Anglo-European College of Chiropractic (AECC)</td>
<td>June/July 2017</td>
<td>122</td>
<td>77</td>
<td>63%</td>
</tr>
<tr>
<td>University of South Wales(^2)</td>
<td>June/July 2017</td>
<td>53</td>
<td>36</td>
<td>68%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td><strong>207</strong></td>
<td><strong>141</strong></td>
<td><strong>68%</strong></td>
</tr>
</tbody>
</table>

What this tells us
A higher percentage of graduates from MCC registered than for the other two colleges as they have a smaller number of overseas students who then return to their home country after completing the course.

Table 4 – percentage of graduates from educational institutions registering from 2013-2016

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

What this tells us
The percentage of graduates registering from the AECC increased markedly in 2017 from a low of 36% in 2016 to 63%. Overall this has increased the number of new registrants for 2017 from the 2016 by 29. It will be interesting to see whether this trend continues or if this is a one-off.

The percentage of MCC graduates applying remains stable at around 87%.

While roughly the same percentage of MCC graduates have registered over the past five years, the percentage of graduates registering from the University of South Wales has decreased significantly for the same period. However, a plateau does now seem to have been reached with approximately two thirds of registrants having registered over the past three years.

---

\(^1\) Graduates from the McTimoney College of Chiropractic 2016 cohorts are included as they first register during the 2017 registration year.

\(^2\) Subject to confirmation
Applicants holding relevant foreign chiropractic qualifications (route 2)

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

Table 6 – new foreign qualified applicants registered during 2017 (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>Institute Franco-Européen de Chiropratique (IFEC)</td>
<td>France</td>
<td>1</td>
<td>2015</td>
</tr>
<tr>
<td>Life University</td>
<td>USA</td>
<td>1</td>
<td>2014</td>
</tr>
<tr>
<td>Life – West University</td>
<td>USA</td>
<td>2</td>
<td>2014 x2</td>
</tr>
<tr>
<td>National University of Health Sciences</td>
<td>USA</td>
<td>1</td>
<td>1996, 2014 x2, 2017</td>
</tr>
<tr>
<td>Macquarie University</td>
<td>Australia</td>
<td>4</td>
<td>2014, 2016 x2, 2017</td>
</tr>
<tr>
<td>New Zealand College of Chiropractic (NZCC)</td>
<td>New Zealand</td>
<td>1</td>
<td>2012</td>
</tr>
<tr>
<td>Palmer College of Chiropractic</td>
<td>USA</td>
<td>1</td>
<td>2008</td>
</tr>
<tr>
<td>Royal Melbourne Institute of Technology (RMIT)</td>
<td>Australia</td>
<td>2</td>
<td>2013, 2014</td>
</tr>
<tr>
<td>University of Johannesburg</td>
<td>South Africa</td>
<td>2</td>
<td>2016, 2017</td>
</tr>
<tr>
<td>University of Western States</td>
<td>USA</td>
<td>1</td>
<td>2016</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>21</strong></td>
<td></td>
</tr>
</tbody>
</table>

What this tells us

Candidates continue to apply from a wide range of colleges, although the same colleges tend to make up the bulk of applicants, including Durban Institute of Technology and Macquarie University. In 2017 there were fewer RMIT candidates but more from DIT, which seems to be a continuing trend.

Three quarters of candidates applied within five years of graduating, and four graduated prior to 2012, including one 1996 graduate.

In 2017 a graduate of the French college, Institut Franco-Européen de Chiropraxie, sat the test, having not been eligible to apply through the EU General Directive.
Table 7 – Test candidates by institution since 2013

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

What this tells us

We received applications from the same colleges in South Africa, Australia and New Zealand previously, which is largely due to the small number of chiropractic colleges outside the US.

While graduates from US colleges do apply to sit the test, those colleges represented vary year on year because of the small number of applicants and high number of colleges. Having said this we have received applications from Life University over the past three years.

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3 Colleges are highlighted to denote 2017 figures.
Test of Competence
The Test of Competence is made up of the following components:

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

2. the candidates chiropractic course is mapped against our Degree Recognition Criteria

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

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

Test outcomes
There are three possible test outcomes, either where:

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

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

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

2017 Test of Competence results
This is the third year the GCC has offered the Test of Competence in its current format, bringing the total number of such tests to date to 12.

33 candidates took the test and 34 attempts were made during 2017; with one candidate taking the test twice. Of those 33 candidates 20 have since registered.

A total of 10 candidates from 2017 were asked to provide further evidence in a total of 25 subjects and so the average number of subjects per candidate was two and a half.
Table 8 – 2017 initial results by individual test

<table>
<thead>
<tr>
<th>Initial test results</th>
<th>Jan-17</th>
<th>Mar-17</th>
<th>Jun-17&lt;sup&gt;4&lt;/sup&gt;</th>
<th>Sept -17</th>
<th>Total</th>
<th>Total %age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pass</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>47%</td>
</tr>
<tr>
<td>Fail</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td>21%</td>
</tr>
<tr>
<td>Insufficient Evidence</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>11</td>
<td>32%</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>9</td>
<td>11</td>
<td>8</td>
<td>34</td>
<td>100%</td>
</tr>
</tbody>
</table>

Figure 7 - comparison of initial test results by percentage between 2015 and 2017

Table 9 – 2017 test results, including final results of those who submitted insufficient evidence before 1 March 2018

<table>
<thead>
<tr>
<th>Initial test results</th>
<th>Jan-17</th>
<th>Mar-17</th>
<th>Jun-17</th>
<th>Sept -17</th>
<th>Total</th>
<th>Total %age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pass</td>
<td>3</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>27</td>
<td>79%</td>
</tr>
<tr>
<td>Fail</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td>21%</td>
</tr>
<tr>
<td>Insufficient Evidence</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>9</td>
<td>11</td>
<td>8</td>
<td>34</td>
<td>100%</td>
</tr>
</tbody>
</table>

What this tells us
Almost half of candidates passed the Test of Competence initially, a figure that rose to 79% once those submitting further evidence were assessed. The pass rate is higher than the previous version of the test, which was generally in the region of 66%.

<sup>4</sup> A candidate who failed the January 2017, went on to pass following a resit in June 2017.
What this tells us
A total of 88 candidates have taken the new version of the test since it was introduced in January 2015.

With 93 attempts at the test over the past three years, the overall failure rate initially appears higher. This is primarily due to the ‘insufficient evidence’ category whereby candidates narrowly failing to convince the panel of their abilities and who would have failed the previous version of the test have an opportunity to submit further evidence in support of their application and may then pass the test. The failure rate was 21% in 2017 was lower than for both 2015 and 2016.

The January 2017 failure rate of 50% was the highest that year, but as only 6 candidates took that test no specific conclusions can be drawn, especially given that the failure rate for the following three tests was much lower.

**Insufficient evidence**
All of the 11 candidates asked to submit further evidence in 2017 have now done so and have passed the test, bringing the final pass rate for 2017 to 79%. In total, further evidence was required on 21 subjects, split between 11 candidates, so several candidates were weak in multiple subject areas. Those candidates are given six months to undertake additional learning and submit evidence of that learning on a range of subjects. The most recurring
subjects are given below. The average number of subjects requiring further evidence per candidate in 2017 was 1.9, representing a drop from 2.5 per candidate in 2016.

Table 11 – number of main subjects with insufficient evidence

<table>
<thead>
<tr>
<th>Subject</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited knowledge of taking and/or maintaining patient records</td>
<td>4</td>
</tr>
<tr>
<td>Insufficient knowledge of common over the counter medications and commonly prescribed medication in the UK</td>
<td>3</td>
</tr>
<tr>
<td>Limited knowledge of evidence based care</td>
<td>2</td>
</tr>
<tr>
<td>Limited knowledge of the management of psychosocial factors</td>
<td>2</td>
</tr>
<tr>
<td>Limited knowledge of CPD learning cycles</td>
<td>2</td>
</tr>
<tr>
<td>Total number of subjects for 2017</td>
<td>21</td>
</tr>
</tbody>
</table>

What this tells us
Overall the subjects represented cover a wider range than previously. Fewer candidates failed on taking and/or maintaining patient records and knowledge of Ionising Radiation.

Figure 9 – number of candidates passing the test following submission of additional evidence

What this tells us
All candidates required to submit additional evidence have since both passed the test and gone on to register.
Nationality of test candidates

Figure 10 - nationality of test candidates

What this tells us
Almost half of the 2017 test candidates were either American or Australian. In 2017, 7 candidates were EU nationals (excluding UK nationals). Of interest are the four French nationals taking the test and who qualified in the US and whose circumstances prevented them from applying through the EU General Directive.

Of those 7 EU candidates, one failed the test and six have passed. The applications of three of those who passed are currently pending, while two have registered as practising and one as non-practising.

Figure 11 – Nationality of test candidates from 2015 to 2017

What this tells us
The numbers applying from individual countries varies, however we normally receive applications from Australians, Americans, Canadians, South Africans and New Zealanders. As stated above, unusually we received applications from 7 nationals of EU countries, all of whom graduated outside the EU.
**Qualification of applicants**

*Figure 12 – number of candidates per college in 2017*

What this tells us

Palmer College of Chiropractic in the US produced the largest number of candidates from any one college, while Macquarie University came a close second with five graduates.
**What this tells us**

Given the numbers graduating from their local educational institutions, it is not surprising that nationality of candidates largely correlates with nationality of college. However, of those 13 graduates from US colleges only 8 were American. The remaining four were EU nationals.

Over the past three years the number of graduates from Macquarie University has decreased from 10 to 2, while there has been an increase of graduates from Palmer College of Chiropractic.
What this tells us
Following a gradual decrease in the number of graduates from Australian colleges over the past few years, there was a slight increase in 2017, and a corresponding decrease of US graduates. Overall numbers from Australia, New Zealand and South Africa fluctuate to a small degree each year. In addition, a graduate from a French college sat the test of competence.

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

Establishment (route 3)
The GCC registered three applicants through the EU General Directive in 2017, which is fewer than in previous years.

Those three registrants applied on the basis that they held EU community rights, were established to practise as chiropractors in a member state of the EEA and intended practising within the UK on a permanent basis; referred to in the Directive as ‘establishment’.

Figure 15 - number of applicants through EU General Directive since 2013

What this tells us
There was a drop in new registrations through the EU General Directive in 2017 and while we cannot be certain of the reason for this, we believe it may be a combination of UK plans to exit the EU and GCC English Language requirements. These requirements were introduced during 2016 and whereas previously we were unable to check an applicant’s English language skills before granting registration, our ability to do so now may have discouraged those with poor language skills from applying.
### Table 12 – educational institution of applicants through the EU directive in 2017

<table>
<thead>
<tr>
<th>Educational institution</th>
<th>Country</th>
<th>Number of registrants</th>
<th>Year of graduation (total graduates in brackets)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insitut Franco-Européen de Chiropraxie (IFEC)</td>
<td>France</td>
<td>3</td>
<td>2012 2016 2017</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>3</td>
<td>-</td>
</tr>
</tbody>
</table>

### Table 13 – nationality of applicants through the EU General Directive

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Number of registrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>French</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
</tr>
</tbody>
</table>

**What this tells us**

Given the small number of applicants through the EU General Directive during 2017, no conclusions can be drawn from the data, which is given here for completeness.

### Temporary and occasional registration (route 4)

In 2017 we received one application for temporary and occasional registration, from an EEA national with a US qualification.

### New registrants

Data collected on initial registration application forms includes sex and date of birth.

**Split by sex of new registrants**

The following data shows the split by sex, of those registered during 2017.

### Figure 16 – sex of new registrants

![Graph showing the sex of new registrants from 2013 to 2017](image-url)
What this tells us
The split between the sexes of those registering for the first time in 2017 was more pronounced that since 2013. This is the first time since 2013 that more males than females have registered, but is insignificant given the small numbers.

Age split of new registrants
The following chart shows the age split of all new registrants between 2013 and 2017.

Figure 17 – percentage split of new registrants by age since 2013

What this tells us
The under 30 group made up the bulk of new registrants as expected since the majority are new graduates, but constitute a higher percentage than previously. We would expect to see some fluctuation in figures although for 2017 this is marked.

Survey of new registrants
During 2017 we conducted a survey of those registered during 2016, which was partly to understand what new registrants were doing and how they practice. Some of those results are given below:

Figure 18 – How many hours a week do you work as a chiropractor?
What this tells us
Nearly three quarters of new registrants work more than 30 hours a week, with a clear majority working an average working week of between 30 and 39 hours.

Figure 18 – What type of practice do you work in?

What this tells us
Three quarters of respondents were working in a stand alone clinic, while the remaining quarter worked in a clinic that was part of a group.

Figure 20 – Do you practice alone or with others?

What this tells us
Overall 25% of those who responded are working alone. We do not know whether this is made up of new graduates or long standing chiropractors from overseas.
Figure 21 – How many chiropractors do you work with?

What this tells us
Of the 75% of respondents working with others the majority (80%) work with more than 1 chiropractor.

Figure 22 – Is being registered important to you?

What this tells us
Over 90% of respondents said that being registered was important for them, half felt it very important.

Figure 23 – Do you make patients aware you are registered with the GCC?

What this tells us
We are pleased that all respondents made patients aware of their registration.
**Trends in initial registration**

The following section gives an indication of future trends in the number of potential new initial registrants. It focuses on graduates from the UK colleges offering accredited courses, which make up the largest number of new registrants each year.

We have not made an estimation of the number of students dropping out of courses before graduation. This is both because the numbers are small, but also as there can be small increases in student numbers as well as decreases.

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

<table>
<thead>
<tr>
<th>Educational institution</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglo-European College of Chiropractic</td>
<td>92</td>
<td>104</td>
<td>110</td>
<td>119</td>
<td>125*</td>
</tr>
<tr>
<td>University of South Wales</td>
<td>78</td>
<td>60</td>
<td>62</td>
<td>83</td>
<td>100</td>
</tr>
<tr>
<td>McTimoney College of Chiropractic</td>
<td>31</td>
<td>39</td>
<td>44</td>
<td>44</td>
<td>49</td>
</tr>
<tr>
<td>South Bank London University</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20*</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>201</td>
<td>203</td>
<td>216</td>
<td>246</td>
<td>294</td>
</tr>
</tbody>
</table>

**What this tells us**

In 2017 there were in the region of 217 UK graduates, a figure that is unlikely to be neared again until 2020, when 216 are expected to graduate. However, the figure will potentially increase to 294 in 2022 as the first cohort of students from South Bank London University graduate and there is also an increase in the three colleges currently offering chiropractic programmes in that year. On current forecasts there are likely to be in the region of 93 more graduates in 2022 than in 2018.

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

<table>
<thead>
<tr>
<th>Educational institution</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK graduates*</td>
<td>133</td>
<td>134</td>
<td>143</td>
<td>162</td>
<td>194</td>
</tr>
<tr>
<td>Foreign Qualified**</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>EU Directive**</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>156</td>
<td>157</td>
<td>166</td>
<td>185</td>
<td>217</td>
</tr>
</tbody>
</table>

* these figures have been calculated based on a registration rate of 66% for UK graduates.
** these figures have been calculated based on the number of registrants through these route to registration in 2017. They have been included in the figures following UK exit from the EU as we do not know whether an alternative mechanism will be adopted, also without the EU route those candidates may well apply to take the Test of Competence.

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5 This figure includes those who started the course at year 0 and an estimate of those who will join the course at year 1.
6 As the first cohort for SBLU does not begin until the 2018/19 Academic year, this figure is an estimate of places available.
What this tells us
Based on the projections shown in figure 13, we anticipate fewer initial registrants over the next three years, but from 2021 there is likely to be an increase in applications, with a potential jump to over 200 in 2022. Given there is a potential then for an increase of in the region of 60 applications, most of whom are likely to apply during the peak July and August period, there may be an impact on office workload during that period.

Retentions
Summary
This section covers the 2017 retention period for the 2018 registration year, which began in mid October and concluded on 15 December 2017.

Each year all those chiropractors on the register as of 10 November are required to complete a retention application form and pay the fee to remain registered for the following year by the statutory deadline of 30 November.

Factors affecting annual retention figures and the number of registrants include those:
- choosing to paying the non-practising fee
- lapsing from the Register at the end of the retention period on 15 December; and
- registering for the first time on or after 10 November, so as only to pay the fee for initial registration and not also for retention.

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

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

By the end of December 2017, 263 chiropractors had paid the non-practising fee, having declared that they did not intend practising in the UK at all during 2018, which represents approximately 8.2% of the profession.
Figure 24 – percentage of registrants paying the non-practising fee since 2012

![Chart showing percentage of registrants paying the non-practising fee from 2012 to 2017.]

What this tells us
Figure 17 gives the percentage of the register population paying the non-practising fee over the past five years. The figure for 2017 shows another decrease in the overall percentage and the lowest recorded. We continue to make it clear to those wishing to register or retain by paying the non-practising rate, that this is only appropriate in the short-term. We spoke to several registrants who wished to pay the lower fee during the retention period and, after advising them of their options, they chose to allow their registration to lapse.

Retainers paying the non-practising fee
Of those 263 paying the non-practising fee, 261 did so through retention and the remaining two did so as part of the initial registration process on or after 10 November 2017.

The various reasons given for paying the non-practising fee are considered below.
Table 16 - reasons given for paying the non-practising registration fee

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of registrants</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working overseas</td>
<td>144</td>
<td>56.4</td>
</tr>
<tr>
<td>Maternity/ Child care</td>
<td>30</td>
<td>11.8</td>
</tr>
<tr>
<td>Not working as a chiropractor</td>
<td>30</td>
<td>11.8</td>
</tr>
<tr>
<td>Sabbatical</td>
<td>16</td>
<td>6.3</td>
</tr>
<tr>
<td>Education</td>
<td>9</td>
<td>3.5</td>
</tr>
<tr>
<td>Travelling</td>
<td>9</td>
<td>3.5</td>
</tr>
<tr>
<td>Role as carer</td>
<td>4</td>
<td>1.5</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
<td>1.2</td>
</tr>
<tr>
<td>Lecturer</td>
<td>3</td>
<td>1.2</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>3</td>
<td>1.2</td>
</tr>
<tr>
<td>Financial</td>
<td>2</td>
<td>0.8</td>
</tr>
<tr>
<td>Health</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Retired</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Total</td>
<td>255</td>
<td>100%</td>
</tr>
</tbody>
</table>

What this tells us

80% of the registrants who paid the non-practising fee did so as they were either practising outside of the GCC’s jurisdiction or were taking a career break for maternity or child care reasons. While we cannot refuse to retain someone on the register based on their reason for paying the non-practising rate, we believe that it a misuse of the register to do so for the reason of retirement from the profession.
Figure 25 - reasons for paying the non-practising registration fee by percentage

<table>
<thead>
<tr>
<th>Reason</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working overseas</td>
<td>60.2</td>
<td>61.7</td>
<td>56.4</td>
</tr>
<tr>
<td>Maternity/Child care</td>
<td>13.1</td>
<td>13.6</td>
<td>11.8</td>
</tr>
<tr>
<td>Not working as a chiropractor</td>
<td>11.5</td>
<td>11.7</td>
<td>11.7</td>
</tr>
<tr>
<td>Education</td>
<td>5.6</td>
<td>5.1</td>
<td>3.5</td>
</tr>
<tr>
<td>Health</td>
<td>3.7</td>
<td>3.7</td>
<td>0.4</td>
</tr>
<tr>
<td>Sabbatical</td>
<td>0.4</td>
<td>0.4</td>
<td>2.2</td>
</tr>
<tr>
<td>Health</td>
<td>6.3</td>
<td>6.3</td>
<td>6.3</td>
</tr>
</tbody>
</table>

What this tells us
Those practising outside of the GCC’s jurisdiction make up a slightly smaller proportion of the total than in 2016 when 61.7% advised us they were doing so. Conversely those not working as chiropractors rose from 4.8% to 11.8% in 2017, although as the retention application form allows free text this may simply be due to reporting and in any case represents a total increase of only 17 registrants.

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

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

Failure to retain on the Register (lapse)
All registrants must provide a retention application form and pay the fee before the retention statutory deadline of 30 November each year. If a complete application does not arrive by the due date a final warning notice is issued allowing registrants a further 14 days to comply. If at the end of the notice period the application has not arrived the registrant is normally removed from the Register.
Failure to complete annual CPD requirements (CPD non compliance)
Each year all registrants must return a completed CPD record summary, giving details of the learning they undertook that year in compliance with our CPD rules and guidance. Registrants not providing a summary, or who fail to meet CPD requirements, may be removed from the Register.

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

Table 17 - method of removal from the Register during 2017 by month

<table>
<thead>
<tr>
<th>Month</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>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>February</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>March</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>April</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</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>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>July</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>August</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>September</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>October</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>55</td>
<td>1</td>
<td>60</td>
</tr>
<tr>
<td>November</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>December</td>
<td>0</td>
<td>82</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>88</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1</strong></td>
<td><strong>83</strong></td>
<td><strong>14</strong></td>
<td><strong>4</strong></td>
<td><strong>55</strong></td>
<td><strong>157</strong></td>
</tr>
</tbody>
</table>

What this tells us
Table 16 shows that the majority of removals from the Register normally fall in October at the end of the CPD period and following retention deadline in December. The remaining removals occur throughout the year and are largely made up of those taking voluntary removal from the Register. The GCC’s Professional Conduct Committee ‘struck-off’ one registrant in 2017.

More registrants came off the Register in 2017 than in previous years as a larger number failed to submit CPD summaries. This may be due to the deeper checks undertaken of
2015/16 CPD summaries, and which may have discouraged those previously paying the non-practising rate from remaining registered.

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

Table 18 – reasons for no longer remaining registered

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of registrants</th>
<th>%age of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown</td>
<td>55</td>
<td>35.0</td>
</tr>
<tr>
<td>Overseas</td>
<td>52</td>
<td>33.1</td>
</tr>
<tr>
<td>Retired</td>
<td>10</td>
<td>6.4</td>
</tr>
<tr>
<td>Missed deadline</td>
<td>9</td>
<td>5.7</td>
</tr>
<tr>
<td>Not working as a chiropractor</td>
<td>5</td>
<td>3.2</td>
</tr>
<tr>
<td>Health</td>
<td>4</td>
<td>2.6</td>
</tr>
<tr>
<td>Child care</td>
<td>4</td>
<td>2.6</td>
</tr>
<tr>
<td>Career Change</td>
<td>4</td>
<td>2.6</td>
</tr>
<tr>
<td>Deceased</td>
<td>4</td>
<td>2.6</td>
</tr>
<tr>
<td>Family reasons</td>
<td>3</td>
<td>1.9</td>
</tr>
<tr>
<td>Pregnancy/ Maternity</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Financial</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Education</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Sabbatical</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Treating animals only</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Struck-off</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>157</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

What this tells us
There are a range of reasons registrants leave the register each year. Excluding those for whom we have no data, those no longer residing in the UK formed the category with the largest number of registrants. The figures themselves do not show anything of concern, although the total number of those leaving should be looked at annually to determine whether the increase in removals is a trend.
Table 1 – fees paid in 2016 by those lapsing from the Register in 2017

<table>
<thead>
<tr>
<th></th>
<th>Number of registrants</th>
<th>As a % of removers</th>
<th>%age of the Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practising</td>
<td>103</td>
<td>65</td>
<td>91.9</td>
</tr>
<tr>
<td>Non-practising</td>
<td>54</td>
<td>35</td>
<td>8.1</td>
</tr>
</tbody>
</table>

What this tells us
A higher percentage of leavers during 2017 had paid the non-practising fee for that year than the profession as a whole. This may be as registrants are initially cautious about relinquishing their registration and prefer to remain registered in case their circumstances change. There is still a perception that restoring to the Register is a complicated process including passing the Test of Competence, although this has never been the case.

Table 20 – Reasons for removal from the Register by fee paid

<table>
<thead>
<tr>
<th>Reason for removal</th>
<th>Practising</th>
<th>Non Practising</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPD non compliance</td>
<td>32 (58%)</td>
<td>23 (42%)</td>
<td>55</td>
</tr>
<tr>
<td>Lapse</td>
<td>57 (69%)</td>
<td>26 (31%)</td>
<td>83</td>
</tr>
<tr>
<td>Struck off</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Voluntary removal</td>
<td>11 (79%)</td>
<td>3 (21%)</td>
<td>14</td>
</tr>
<tr>
<td>Deceased</td>
<td>3 (75%)</td>
<td>1 (25%)</td>
<td>4</td>
</tr>
</tbody>
</table>

What this tells us
Table 19 compares the registration rate of those leaving the Register by reason. Those registered as practising make up the largest percentage in all categories. Of interest are the figures for those removed for CPD non-compliance, showing that 42% were non-practising, a figure that has dropped year on year for the third year in a row; previously 64% has been non-practising in 2015 and 51% in 2016.

---

7 Figure for 31 December 2016
Diversity of the Register

Split of the Register by sex

Figures 26 – percentage split of registrants by sex since 2006

What this tells us
While there is a near 50:50 split between female and male chiropractors, male chiropractors currently outnumber their female colleagues by a tiny fraction of half a percent. Given that the reversal is largely due to more male chiropractors being granted registration for the first time in 2017 and therefore represents a small number of registrants, this could be reversed easily.

Split of the Register by age

Figure 27 – percentage split of registrants by age since 2006
What this tells us
The age split of those registered remains relatively static, with a very gradual increase in the number of registrants over 45.
Communications
During 2017 the registrations team engaged with stakeholders in a number of areas.

New Continuing Professional Development (CPD) The GCC published updated guidance to assist registrants completing their annual CPD return.

CPD learning points
Following the annual check of CPD returns, we published learning points based on our findings, highlighting the most common errors. We hope that sharing this with the profession will reduce errors in the future.

Additional guidance
We have reviewed published guidance throughout 2017 to aid completion of the various registration processes, including on expected levels of English language skills for applicants and registrants as well as various aspects of the registration process, such as requirements for character references, what we mean by professional standing and also a medical report pro-forma for GP’s.
For further information on registrations or CPD, please contact:
Registrations team
General Chiropractic Council
44 Wicklow Street
London
WC1X 9HL
020 7713 5155 x5501
www.gcc-uk.org
enquiries@gcc-uk.org
To: General Chiropractic Council
From: Richard Kavanagh, Business Information Officer
Subject: Annual FTP statistics report
Date: 21 March 2018

Purpose

1. The purpose of the report is to present to Council the Annual FTP statistics report covering the period to 1 January 2017 to 31 December 2017.

2. Equality data relating to FTP is included in the EDI annual report.

Background


Action required

4. Council is asked to note the report.

Financial implications

5. There are no financial implications arising from this paper

Legal or Risk Implications

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

Equality Implications

7. There are no equality implications arising from this paper

Communications Implications

8. The report will be published on the website following the meeting
Annual Fitness to Practise statistics report

2017
Preface

Caution should be exercised when considering the data in the following report.

The General Chiropractic Council receives a limited amount of complaints per year which means that small numbers can impact dramatically on percentages and totals, in some cases skewing the figures. It would be inappropriate and potentially misleading to draw broad conclusions from the report.
About Fitness to Practise (FTP)

The Code

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


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

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

Investigating complaints

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

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

What complaints are the GCC unable to investigate?

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

- We receive a written complaint.
- We carry out an investigation.
- We invite the complainant to give us a statement of evidence.
  We may get more information from the complainant and other witnesses.
- We send a copy of the complaint or statement to the chiropractor, who has 28 days to give observations.
  If relevant, we obtain chiropractic records.
- We send the chiropractor’s observations to the complainant for comments.
  Any comments are sent to the chiropractor for additional observations.
- The Investigating Committee considers all the documentary evidence provided by both parties.
  The Committee may ask for more information before making a final decision.
- **Case to answer**
  The Committee draws up an allegation for referral to the Professional Conduct Committee or Health Committee. We tell the chiropractor and the complainant the reason for the decision.
- **No case to answer**
  Case closed. We tell the chiropractor and the complainant the reason for the decision.
FTP Committees

The GCC has three statutory committees concerned with chiropractors’ conduct (including criminal convictions), professional incompetence and physical and mental health.

Investigating Committee

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

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

Professional Conduct Committee

The PCC determines allegations about a chiropractor’s conduct or professional incompetence referred to it by the Investigating Committee. Allegations that have been referred to the PCC are considered either at a public hearing or at a private meeting.

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

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

Sanctions available to the PCC are

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

Health Committee

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

The HC did not meet in 2017.
FTP at a glance

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of cases considered by Investigating Committee</td>
<td>74</td>
<td>51</td>
</tr>
<tr>
<td>Number of cases concluded by Investigating Committee</td>
<td>67</td>
<td>43</td>
</tr>
<tr>
<td>Number of cases concluded by Investigating Committee with the following outcome:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NICTA and Withdrawn/Closed</td>
<td>51</td>
<td>28</td>
</tr>
<tr>
<td>Referral to Fitness to Practise Committee</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>Number of individual cases considered by a final Fitness to Practise Committee</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td>Number of cases concluded by a final Fitness to Practise Committee</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>Time from receipt of initial complaint to the final Investigating Committee decision (in weeks):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>30</td>
<td>33</td>
</tr>
<tr>
<td>Longest case</td>
<td>129</td>
<td>157</td>
</tr>
<tr>
<td>Shortest case</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Number of open cases (at the end of the year) which are older than:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>52 weeks</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>104 weeks</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>156 weeks</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of occasions a case has been referred to another investigating body/regulator:</td>
<td>8</td>
<td>2</td>
</tr>
</tbody>
</table>

Key achievements

- More complaints were considered and concluded by the IC in 2017 than 2016 even though a larger amount of complaints were received
- Despite the increase in the number of complaints concluded from 2016 (43) to 2017 (67), the percentage of allegations referred to PCC was lower
- The median time taken to deal with complaints at the IC stage has reduced
- More allegations were considered and concluded at the PCC in 2017 than 2016, including older cases and cases of a complicated nature
- A backlog of older complaints was concluded by the IC, with 52% of the cases determined in 2017 being received in the same year. This has led to a reduction in the number of open cases that were older than 52 weeks at the year end which went down from 12 to 5
Complaints received

In 2017, the number of complaints received about chiropractors’ fitness to practise rose to its highest level since 2013.

There were 66 complaints received in 2017. There were 61 complaints against separate chiropractors.

Two registrants received two complaints against them and one registrant received three complaints against them in the year.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints received</td>
<td>66</td>
<td>43</td>
<td>56</td>
<td>65</td>
<td>80</td>
</tr>
</tbody>
</table>

Complaints received by month

On average we received almost six complaints per month in 2017 with a peak of 10 complaints in March 2017.

---

1 This number may change as time progresses. Some ‘enquiries’ that we receive in a year may not be deemed a section 20 ‘complaint’ initially or at all. The date the ‘complaint’ is received may overlap with the date that we decide it has become a section 20 matter, for example, an enquiry could be received in 2017, but the decision that it should be considered as a section 20 ‘complaint’ may not occur until 2018.

2 In 2016, the GCC received a large number of complaints that related to advertising claims made on registered chiropractors’ websites. For the purpose of this section these have been excluded.
Source of complaints

An analysis of the complaints that we received shows that predominantly the complaints were made by a patient or a relative of a patient. These account for 79% of all complaints.

The split of the complaints is as follows:

<table>
<thead>
<tr>
<th>Source of Complaints</th>
<th>2017</th>
<th>2017 %</th>
<th>2016</th>
<th>2016 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Relative of</td>
<td>52</td>
<td>79%</td>
<td>25</td>
<td>58%</td>
</tr>
<tr>
<td>Chiropractor/Clinic where worked</td>
<td>2</td>
<td>3%</td>
<td>3</td>
<td>7%</td>
</tr>
<tr>
<td>Public Sector Org (e.g. Police)</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Member of public/private org.</td>
<td>2</td>
<td>3%</td>
<td>8</td>
<td>19%</td>
</tr>
<tr>
<td>Registrar</td>
<td>3</td>
<td>5%</td>
<td>5</td>
<td>12%</td>
</tr>
<tr>
<td>Self Referral</td>
<td>1</td>
<td>2%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Anonymous</td>
<td>6</td>
<td>9%</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>66</td>
<td>43</td>
<td>43</td>
<td>43</td>
</tr>
</tbody>
</table>
**Nature of complaints**

A review has been undertaken into the allegations made by complainants for every complaint received in 2017 in order to better understand the nature of complaints received in the period.

**Approach**

The initial case reports for each complaint were reviewed and the issues captured by the case worker were then captured and classified into separate categories and then sub categories. It is important to note that initial case reports are ordinarily used as a summary for the caseworker of the issues that have been identified at the earliest stage of the investigation i.e. when we receive the complaint. It is possible that further matters could be identified during the investigation process, but these, if identified, are not included in this report. Complaints from patients can sometimes be difficult to assess and specifically set a category for, making the case reports somewhat subjective, however all case reports are reviewed by the head of investigations which gives consistency to the process.

We have continued to use the categories that were first utilised in a previous report commissioned by the GCC in March 2014.

The categories are split into category then further broken down into type and, in some cases, subtype.

<table>
<thead>
<tr>
<th>Category</th>
<th>Type</th>
<th>Subtype</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical care</td>
<td>e.g. substandard care/inadequate record keeping etc.</td>
<td>e.g. treatment causing injury/misdiagnosis</td>
</tr>
<tr>
<td>Probity</td>
<td>e.g. relating to patient data/misleading advertising etc.</td>
<td>e.g. Improper alteration of patient notes</td>
</tr>
<tr>
<td>Relationships with patients</td>
<td>e.g. communication/consent/sexual boundaries etc.</td>
<td>e.g. Rudeness/failure to explain adequately</td>
</tr>
<tr>
<td>Working with colleagues</td>
<td>e.g. failure to share relevant information with colleagues etc.</td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td>e.g. substance abuse/other</td>
<td></td>
</tr>
<tr>
<td>Conviction/Caution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching/Supervision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with GCC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>investigations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business/employment issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Nature of complaint by category

In 67% of complaints there were multiple allegations made by a complainant against a chiropractor. On average there are over two separate allegations made per complaint. Often a single complaint contained allegations about both clinical care and relationships with patients, thus crossing ‘category’. Of the 66 complaints received, there were 43 separate complaints that in some way alleged a failing relating to clinical care. In 30 of these complaints (a percentage of 70%) there were also allegations made that related to a breakdown in the relationship between chiropractor and patient.

In previous FTP reports the allegation raised by the complainant that is considered most prevalent or most serious by the FTP team was used as the category of the complaint. For example, if a patient has been severely injured and the chiropractor showed limited empathy, this complaint would have been categorised as ‘clinical care’ only, despite their being issues relating to ‘relationships with patients’ also present. In this report, all allegations made, including multiple allegations by one complainant, have been captured separately. It is for this reason that the numbers that follow will be considerably larger than the number of complaints received in the year (66³).

Base: 66 cases

<table>
<thead>
<tr>
<th>Nature of Complaint</th>
<th>Number of allegations raised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical care</td>
<td>88</td>
</tr>
<tr>
<td>Relationships with patients</td>
<td>77</td>
</tr>
<tr>
<td>Probit</td>
<td>10</td>
</tr>
<tr>
<td>Conviction/Caution</td>
<td>4</td>
</tr>
<tr>
<td>Working with colleagues</td>
<td>1</td>
</tr>
<tr>
<td>Business/employment issues</td>
<td>1</td>
</tr>
<tr>
<td>Health</td>
<td>0</td>
</tr>
<tr>
<td>Teaching/Supervision</td>
<td>0</td>
</tr>
<tr>
<td>Compliance with GCC investigations</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
</tbody>
</table>

The largest number of allegations for the period related to clinical care and relationships with patients. A further breakdown of clinical care and relationships with patients follows.

³ Complaints that became section 20 in 2017
Clinical care by type and subtype

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

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of allegations raised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substandard treatment</td>
<td>80</td>
</tr>
<tr>
<td>Inadequate record keeping</td>
<td>1</td>
</tr>
<tr>
<td>Poor hygiene practice</td>
<td>0</td>
</tr>
<tr>
<td>Breach of patient confidentiality</td>
<td>7</td>
</tr>
</tbody>
</table>

Substandard treatment

A further breakdown of substandard treatment by subtype shows that there are several clinical care issues that are alleged. The most common allegation in this subtype is treatment causing pain and/or injury; however there is a much wider spread of issues within the subtype.

<table>
<thead>
<tr>
<th>Subtype (Substandard treatment)</th>
<th>Number of allegations raised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate or excessive treatment/lack of clinical justification</td>
<td>14</td>
</tr>
<tr>
<td>Concern about treatment techniques/approach/dissatisfied with treatment</td>
<td>12</td>
</tr>
<tr>
<td>Rough/aggressive treatment causing injury or pain</td>
<td>16</td>
</tr>
<tr>
<td>Failure to work within limits of knowledge, skills and competence</td>
<td>2</td>
</tr>
<tr>
<td>Misdiagnosis/No diagnosis</td>
<td>5</td>
</tr>
<tr>
<td>Inadequate assessment/case history</td>
<td>5</td>
</tr>
<tr>
<td>Lack of clinical justification for investigations/x-rays</td>
<td>3</td>
</tr>
<tr>
<td>Lack of further investigation/follow up/review</td>
<td>11</td>
</tr>
<tr>
<td>Failure to refer, when appropriate</td>
<td>6</td>
</tr>
<tr>
<td>Failure to examine/inadequate examination</td>
<td>0</td>
</tr>
<tr>
<td>Failure to cease treatment</td>
<td>6</td>
</tr>
</tbody>
</table>
Relationships with patients by type and subtype

The second largest category of complaint is relationships with patients.

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of allegations raised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>48</td>
</tr>
<tr>
<td>Consent</td>
<td>14</td>
</tr>
<tr>
<td>Sexual boundaries</td>
<td>3</td>
</tr>
<tr>
<td>Failure to preserve patient's privacy and dignity</td>
<td>3</td>
</tr>
<tr>
<td>Failure/delays in providing access to records</td>
<td>1</td>
</tr>
<tr>
<td>Intimidation of patient/pressure/undue influence to undergo treatment</td>
<td>8</td>
</tr>
</tbody>
</table>
Allegations about communication were the most frequently occurring type of allegation in respect of relationships with patients.

A further breakdown of communication by subtype shows the different issues that are complained about.

<table>
<thead>
<tr>
<th>Subtype (Communication)</th>
<th>Number of allegations raised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rudeness to patient/lack of respect or sympathy</td>
<td>20</td>
</tr>
<tr>
<td>Inappropriate comments/language</td>
<td>5</td>
</tr>
<tr>
<td>Failure to explain fees adequately/mechanisms for payment</td>
<td>2</td>
</tr>
<tr>
<td>Failure to explain or agree diagnosis/treatment or treatment plan/results</td>
<td>13</td>
</tr>
<tr>
<td>Failure to provide adequate information about complaints procedure</td>
<td>6</td>
</tr>
<tr>
<td>Failure to explain refusal to treat</td>
<td>2</td>
</tr>
</tbody>
</table>

The most common occurring complaint received related to the chiropractor being rude/showing lack of respect or sympathy to the patient. This is often alleged in conjunction with a clinical care based failing.

A large number of complaints raised the subtype ‘failure to explain or agree diagnosis/treatment or treatment plan/results’. In all but one of these complaints received, this was alleged in conjunction with a substandard care based failing.
Consent

All 14 of the allegations made relating to consent allege that the chiropractor failed to obtain informed consent from the patient.

Sexual boundaries

There was a decrease in sexual boundaries complaints made to the GCC in 2017. This follows a reduction trend that began between 2015 and 2016.

Commonly occurring allegations in 2017

The most commonly occurring allegations were

- Substandard treatment - Rough/aggressive treatment causing injury/pain
- Substandard treatment - Inappropriate or excessive treatment/lack of clinical justification
- Communication - failure to explain or agree diagnosis/treatment or treatment plan/results
- Communication - rudeness to patient/lack of respect or sympathy/empathy
- Consent - failure to obtain informed consent

As mentioned previously, these allegations often formed part of a more substantive complaint where multiple separate issues were raised.

Advertising cases

In 2016, we received a large number of allegations that related to advertising claims made on registered chiropractors’ websites, all of which originated from one organisation. The cases are being progressed and it is envisaged that the majority will have been considered by the IC by the end of 2018.
Investigating Committee

In 2017, the Investigating Committee determined 67 cases. In 2016, the Investigating Committee determined 43 cases. This is an increase of 55%, despite the higher volume of complaints in the period.

<table>
<thead>
<tr>
<th>Year complaint received</th>
<th>2017</th>
<th>2017 (%)</th>
<th>2016</th>
<th>2016 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td></td>
<td></td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>7</td>
<td>10%</td>
<td>25</td>
<td>58%</td>
</tr>
<tr>
<td>2016</td>
<td>25</td>
<td>37%</td>
<td>17</td>
<td>40%</td>
</tr>
<tr>
<td>2017</td>
<td>35</td>
<td>52%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
<td></td>
<td>43</td>
<td></td>
</tr>
</tbody>
</table>

Cases determined by month

![Bar chart showing cases determined by month]

Determinations by year complaint received

Of the 67 cases that were determined in 2017, 7 of the complaints were received in 2015, 25 were received in 2016 and 35 were received in 2017.
**Time taken for IC cases to be determined**

We aim to complete cases in a timely manner.

Of the 67 cases determined by the IC, 47 were determined within 9 months of the complaint being received. This was a percentage of 70%.

<table>
<thead>
<tr>
<th>IC Cases Determined</th>
<th>2017</th>
<th>%</th>
<th>2016</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 4 months</td>
<td>12</td>
<td>18%</td>
<td>4</td>
<td>9%</td>
</tr>
<tr>
<td>Within 6 months</td>
<td>16</td>
<td>24%</td>
<td>9</td>
<td>21%</td>
</tr>
<tr>
<td>Within 9 months</td>
<td>19</td>
<td>28%</td>
<td>17</td>
<td>40%</td>
</tr>
<tr>
<td>Over 9 months</td>
<td>20</td>
<td>30%</td>
<td>13</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>67</td>
<td></td>
<td>43</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Jan - Mar</th>
<th>Apr - Jun</th>
<th>Jul – Sep</th>
<th>Oct - Dec</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases closed within 4 months</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Cases closed within 5 - 6 months</td>
<td>1</td>
<td>1</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Cases closed within 7 - 9 months</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Cases closed after 9 months</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
</tr>
</tbody>
</table>

% closed within 9 months: 70%

**Open IC cases at the year end**

At the end of 2017, there were 32 cases that were awaiting a decision by the Investigating Committee.

<table>
<thead>
<tr>
<th>Open IC cases at year end</th>
<th>2017</th>
<th>%</th>
<th>2016</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 4 months</td>
<td>16</td>
<td>50%</td>
<td>10</td>
<td>30%</td>
</tr>
<tr>
<td>Within 6 months</td>
<td>10</td>
<td>31%</td>
<td>5</td>
<td>15%</td>
</tr>
<tr>
<td>Within 9 months</td>
<td>4</td>
<td>13%</td>
<td>8</td>
<td>24%</td>
</tr>
<tr>
<td>Over 9 months</td>
<td>2</td>
<td>6%</td>
<td>10</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>32</td>
<td></td>
<td>33</td>
<td></td>
</tr>
</tbody>
</table>
Decisions of the Investigating Committee

Of the 67 cases that were determined by the IC in 2017, 16 were referred on to the Professional Conduct Committee (24%). This is a reduction in percentage from 2016.

<table>
<thead>
<tr>
<th>Decision of the IC</th>
<th>2017</th>
<th>%</th>
<th>2016</th>
<th>%</th>
<th>2015</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Case to Answer/Closed</td>
<td>51</td>
<td>76%</td>
<td>28</td>
<td>65%</td>
<td>28</td>
<td>68%</td>
</tr>
<tr>
<td>Referred to PCC</td>
<td>16</td>
<td>24%</td>
<td>15</td>
<td>35%</td>
<td>13</td>
<td>32%</td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
<td></td>
<td>43</td>
<td></td>
<td>41</td>
<td></td>
</tr>
</tbody>
</table>

Decisions of the IC 2017

- **NCTA or closed**: 76%
- **PCC**: 24%
Professional Conduct Committee

In 2017 there were 15 hearings where a determination was made by the PCC.

Two complaints referred from the investigating committee were joined and heard at the same hearing. Therefore, 16 complaints were dealt with by the PCC.

Eight chiropractors were found guilty of unacceptable professional conduct in 2017.

One chiropractor was removed from the register, two received suspension orders and five received an admonishment.

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

The GCC offered no evidence in one hearing (two complaints joined).

<table>
<thead>
<tr>
<th>PCC decision</th>
<th>2017</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removal</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Suspension</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Conditions of Practice</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Admonishment</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>No UPC</td>
<td>6</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>GCC offered no evidence</td>
<td>2</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
<td><strong>13</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

PCC Caseload

At the end of 2017 there were 9 cases that were still to be determined by the PCC. There were 12 PCC cases at the same time in 2016. This is a 25% decrease in open cases at the PCC stage.
Interim Suspension Hearings

Investigating Committee

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

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

There were seven IC interim suspension hearings held in 2017. One chiropractor was suspended as a result of these hearings.

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

Professional Conduct Committee

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

There were two PCC interim suspension hearings held in 2017. One chiropractor was suspended as a result of these hearings.

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>%</th>
<th>2016</th>
<th>%</th>
<th>2015</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not interim suspended</td>
<td>1</td>
<td>50%</td>
<td>0</td>
<td>0%</td>
<td>2</td>
<td>67%</td>
</tr>
<tr>
<td>Suspended</td>
<td>1</td>
<td>50%</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>33%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2</strong></td>
<td><strong>0</strong></td>
<td><strong>3</strong></td>
<td><strong>33%</strong></td>
<td><strong>2</strong></td>
<td><strong>67%</strong></td>
</tr>
</tbody>
</table>
To: General Chiropractic Council
From: Richard Kavanagh, Business Information Officer
Subject: Annual EDI report
Date: 21 March 2018

Purpose

1. The purpose of the report is to present to Council the Annual EDI report covering the period to 1 January 2017 to 31 December 2017.

Background

2. As an employer and as a regulator the GCC is subject to the requirements of the Equality Act 2010 which sets out the protected characteristics and the behaviour that is unlawful.

Action required

3. Council is asked to note the report.

Financial implications

4. There are no financial implications arising from this paper

Legal or Risk Implications

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

Equality Implications

6. There are no equality implications arising from this paper as we are seeking to ensure that we have more relevant information to comply with our obligations

Communications Implications

7. The report will be published on the website following the meeting
Introduction

The General Chiropractic Council (GCC) regulates chiropractors in the UK to ensure the safety of patients undergoing chiropractic treatment. The GCC is an independent statutory body established by Parliament to regulate the chiropractic profession. We protect the health and safety of the public by ensuring high standards of practice in the chiropractic profession.

The General Chiropractic Council is committed to ensuring that all our activities, as a regulator, a service provider and an employer, provide equality of opportunity. We value diversity and aim to ensure that our work is free from discrimination.

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

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

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

Our vision is to be a respected regulator of a trusted profession. Embedding equality, diversity and inclusion assists this goal.
Objectives and Key Achievements

Since agreeing our EDI Scheme we have been working to meet our objectives and increase our work relating to EDI, embedding it within the organisation. We continued to make progress with our equality objectives in 2017. Key achievements for the year include:

**Governance**

In August 2017 the Governance manual was published. The Governance manual includes various references to our duties and our expectations in relation to Equality, Diversity and Inclusion for partners, council members and suppliers to be aligned with our organisational ethos.

**Training**

From the end of 2017, the GCC have been working with a Learning and Development Specialist team who will be providing unconscious bias training for our Council, Staff, FTP Committees and Test of Competence assessors in 2018. The training will differ for each group, however, the same consistent thread (GCC’s EDI messages, objectives, expectations and values) will be communicated to council, staff and committees creating a connection that supports quality and consistency between those making decisions within or on behalf of the organisation.

**Recruitment**

There were a number of recruitment drives in 2017. The GCC recruited for council members, lay and registrant members for the Investigating Committee, Education Committee members and Education visitors.

Twelve new members of the Investigating Committee were recruited in 2017. The recruitment process was carried out in-house. The roles were advertised online on Guardian Jobs, The Times and diversityjobs.co.uk to actively try and increase the diversity of candidates. Over 180 applications were received for six lay member appointments. All applications were anonymised until after the shortlisting process. Candidates were identified by number only and the panel only saw information relating to employment history and professional/educational qualifications. The panel was not aware of candidates’ names, age, race or gender. The process proved a success and the twelve members recruited were a diverse mix of people.

Four new council members, including the Chair, were recruited and inducted in 2017. The recruitment process was conducted by an external agency. As part of the process, and on behalf of the GCC, the external agency promoted the roles through a number of different avenues including diversity organisations such as Women in Business, Women on Boards, Stonewall and the Asian Business Network and BME communities. The external agency also networked through key national communities to attract a diverse range of applicants, including Ethnic Professional Network, Asian Voice/Asian Late, The Voice, Network of Black 200
Professionals and Disability Now. The registrant council member role was advertised to all chiropractic members on the register via an email sent from the register database to all registrants on 23 January 2017. This was followed up by an article in the GCC newsletter.

In June 2017 one registrant and two lay members of the Education Committee were recruited and appointed to replace those who had come to the end of their terms of office. In addition to this, six registrant and nine lay persons were appointed to take on the new role of a GCC Education Visitor. Education Visitors are responsible for advising the Education Committee on the approval and quality assurance of chiropractic degree courses. The recruitment processes for both roles were carried out internally. All equality and diversity information was removed from application forms prior to the shortlisting process. Applicants were selected for interview by panels made up of Council and Committee members and an external panel member. The selection panels were unaware of applicants’ equality data during the shortlisting process.

Data gathered as part of recruitment processes will also be used to inform decision-making about future recruitment drives.

Data

The equality data that we hold relating to registrants increased in 2017 leading to a better understanding of the profile of our registrants and applicants. Both our information relating to religion or belief and sexual orientation increased.

We have carried out more analysis of demographics within FTP and relating to the Test of Competence that we have not done previously.

See the ‘Demographics’ section for more details.

Test of Competence

The Test of Competence is reviewed every year by an external examiner to ensure that the process remains proportionate, fit for purpose and fair.

In 2017, the external examiner stated that each interview was professionally conducted. Chairs demonstrated appropriate leadership and sensitivity. TOC outcomes were considered to be “appropriate and fair”, and the process was considered in accordance with established guidelines. No issues were raised in relation to any equality issues as part of the annual review.

New publications

In 2017, Council approved the new Education Standards and Quality Assurance Handbook, implementing it in September 2017. EDI was a core part of this, requiring institutions to ensure equality of opportunity and to demonstrate in their application how they promote EDI, paying particular attention to the recruitment of students, access, resources and support and monitoring.
**Policy implementation**

Equality impact assessments continue to be considered when new policies are being formulated and equality implications are built into any high level issues that require a decision for the Council.

Equality Analysis training undertaken previously has enabled decision makers to become better informed in order to follow requisite procedures in relation to policy implementation.

**Staff**

In January 2017 the GCC staff received training from the Samaritans charity, with the purpose of equipping the team with the skills and confidence when encountering vulnerable people in person or on the phone.

Internal recruitment in 2017 successfully maintained the strong diversity profile of the GCC staff team.

The EDI induction pack that was developed in 2016 continues to be used for new starters. This details the GCC’s approach and objectives in relation to EDI and sets out responsibilities and expectations of employees.

There has been a significant increase in the staff’s awareness of EDI issues on a day-to-day basis with more staff consulting the EDI champion in relation to queries they have relating to their work.

Staff policies are in the process of being reviewed and updated - EDI being a key consideration throughout, reflecting the GCC’s values.

**Welsh Language Standards**

The GCC formally responded to the Welsh government consultation White Paper “Striking the right balance.” The GCC continues to work with the other healthcare regulators in relation to this work.

**Continuing work**

The GCC continues to be regularly represented at the joint healthcare regulators equality, diversity and inclusion forum. The forum enables an opportunity for regulators to share ideas and current projects with others.

Reasonable adjustments are offered and considered as part of our work across the organisation. Publications are available in large text and languages other than English, on request.

We use an accessible hearing venue that is appropriate for our FTP hearings. An interpreter/translation service is available as part of the hearings process, if required.
We seek to ensure that our consultations, surveys and research projects address equality and diversity issues, and that there is an appropriate diversity of respondents.

**Going forward**

**Our strategic objectives for 2018-2020**

Our Strategic Statement for 2018-2020 sets out the three, linked, high level strategic objectives we will be working to achieve and the outcomes we expect. The three strategic objectives are:

- Enhancing professionalism in order to improve public protection and the quality of patient care and to increase public confidence in the profession
- Contributing to development of the profession
- Delivering effective and efficient regulation

**Updated scheme**

The EDI strategy for 2018 – 2020 will work in conjunction with the strategic objectives, embedding EDI considerations within the relevant projects. It is envisaged that an updated scheme will be published later in 2018.

**Increased data gathering and analysis**

While we have increased the level of data that we hold in a variety of areas in the year, we will also be reviewing the data we currently hold for relevance and look to identify any gaps in our data.
Demographics

Caution should be exercised when considering the data that follows. It would be inappropriate and potentially misleading to draw broad conclusions or assumptions from the report.

Registrants

There has been limited change to our registrant demographics from 2016 to 2017.

Sex

The gender profile of the profession remains the same.

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>

Age

<table>
<thead>
<tr>
<th>Age range</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 29</td>
<td>16%</td>
<td>15%</td>
</tr>
<tr>
<td>30 - 39</td>
<td>30%</td>
<td>31%</td>
</tr>
<tr>
<td>40 - 49</td>
<td>26%</td>
<td>26%</td>
</tr>
<tr>
<td>50 - 59</td>
<td>19%</td>
<td>20%</td>
</tr>
<tr>
<td>60+</td>
<td>9%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Disability

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>69%</td>
</tr>
<tr>
<td>Unknown</td>
<td>30%</td>
</tr>
<tr>
<td>Yes</td>
<td>1%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>0%</td>
</tr>
</tbody>
</table>

Ethnicity

<table>
<thead>
<tr>
<th>Asian / Asian British – Indian</th>
<th>1.6%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian / Asian British – Pakistani</td>
<td>0.2%</td>
</tr>
<tr>
<td>Asian / Asian British - Bangladeshi</td>
<td>0.1%</td>
</tr>
<tr>
<td>Asian / Asian British – Chinese</td>
<td>0.5%</td>
</tr>
<tr>
<td>Asian / Asian British – other</td>
<td>0.9%</td>
</tr>
<tr>
<td>Total Asian</td>
<td>3.3%</td>
</tr>
<tr>
<td>Black/African/Caribbean/Black British - African</td>
<td>0.2%</td>
</tr>
<tr>
<td>Black/African/Caribbean/Black British - Caribbean</td>
<td>0.2%</td>
</tr>
<tr>
<td>Black/African/Caribbean/Black British – other</td>
<td>0.3%</td>
</tr>
<tr>
<td>Ethnic Group</td>
<td>Percentage</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Total Black</td>
<td>0.6%</td>
</tr>
<tr>
<td>Mixed/Multiple ethnic groups – White and Black Caribbean</td>
<td>0.1%</td>
</tr>
<tr>
<td>Mixed/Multiple ethnic groups - White and Black African</td>
<td>0.1%</td>
</tr>
<tr>
<td>Mixed/Multiple ethnic groups – White and Asian</td>
<td>0.3%</td>
</tr>
<tr>
<td>Mixed/Multiple ethnic groups – other</td>
<td>0.7%</td>
</tr>
<tr>
<td><strong>Total Mixed</strong></td>
<td><strong>1.2%</strong></td>
</tr>
<tr>
<td>White – English/Welsh/Scottish/Northern Irish/British</td>
<td>67.1%</td>
</tr>
<tr>
<td>White – Irish</td>
<td>0.6%</td>
</tr>
<tr>
<td>White – other</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Total White</strong></td>
<td><strong>68.1%</strong></td>
</tr>
<tr>
<td>Unknown</td>
<td><strong>26.8%</strong></td>
</tr>
</tbody>
</table>

**Sexual Orientation**

<table>
<thead>
<tr>
<th>Orientation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown</td>
<td>71.1%</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>26.9%</td>
</tr>
<tr>
<td>Gay or Lesbian</td>
<td>1.3%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>0.6%</td>
</tr>
<tr>
<td>Bisexual</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

**Religion or belief**

<table>
<thead>
<tr>
<th>Belief</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown</td>
<td>71%</td>
</tr>
<tr>
<td>Christian</td>
<td>12%</td>
</tr>
<tr>
<td>No Religion</td>
<td>12%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
</tr>
<tr>
<td>Buddhist</td>
<td>1%</td>
</tr>
<tr>
<td>Sikh</td>
<td>0%</td>
</tr>
<tr>
<td>Muslim</td>
<td>0%</td>
</tr>
<tr>
<td>Hindu</td>
<td>0%</td>
</tr>
<tr>
<td>Jewish</td>
<td>0%</td>
</tr>
</tbody>
</table>

The information that we hold for gender assignment, pregnancy and maternity and marital status is limited; for this reason we have not published it here.
Registrants subject to FTP proceedings

As part of out statutory duty, the GCC receives and determines complaints. If there is a ‘case to answer’ at the Investigating Committee stage, it is referred to the Professional Conduct Committee. For more information please see the annual FTP statistics report.

New complaints received against a Chiropractor

The GCC received 66 complaints against registered chiropractors within 2017.

Male chiropractors continue to receive more complaints than female chiropractors, however there has been a decrease in the percentage of complaints that male chiropractors received from 2015 and 2016.

<table>
<thead>
<tr>
<th>Sex</th>
<th>Complaints received in year</th>
<th>2017 %</th>
<th>2016 %</th>
<th>2015 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>42</td>
<td>64%</td>
<td>84%</td>
<td>83%</td>
</tr>
<tr>
<td>Female</td>
<td>24</td>
<td>36%</td>
<td>16%</td>
<td>17%</td>
</tr>
<tr>
<td>Total</td>
<td>66</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Complaints determined against a Chiropractor

There were 67 complaints determined by the Investigating Committee in 2017.

51 of the complaints were closed (‘no case to answer’) and 16 were referred on to the PCC stage. Coincidentally, 51 of the complaints determined were made against male chiropractors and 16 were against female chiropractors.

29.4% of complaints made against male chiropractors were referred to the PCC.

6.3% of complaints made against female chiropractors were referred to the PCC.

The percentage of complaints made against males that progressed to the PCC vs complaints against females is disproportionate. 15 male chiropractors (22.4% of all complaints) were referred to the PCC stage and only 1 female (1.5% of all complaints) was referred on.
Of all the complaints that were referred to PCC, 93.8% were male and 6.3% were female.

<table>
<thead>
<tr>
<th>Complaints determined</th>
<th>NCTA</th>
<th>PCC</th>
<th>Referral rate (within sex)</th>
<th>Referral rate (Male vs Female)</th>
<th>Referral rate (Overall)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>51</td>
<td>36</td>
<td>76.1%</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>29.4%</td>
<td>93.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>22.4%</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>16</td>
<td>15</td>
<td>23.9%</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6.3%</td>
<td>6.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.5%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
<td>51</td>
<td>100%</td>
<td>16</td>
<td>16</td>
</tr>
</tbody>
</table>

### Age

There were less cases determined that were against younger chiropractors.

There is a higher referral rate to PCC for chiropractors that are aged 40 and above.

<table>
<thead>
<tr>
<th>Complaints determined</th>
<th>NCTA</th>
<th>PCC</th>
<th>Referral rate (within age group)</th>
<th>Referral rate (group vs group)</th>
<th>Referral rate (Overall)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>5</td>
<td>5</td>
<td>7.5%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>30-39</td>
<td>15</td>
<td>13</td>
<td>22.4%</td>
<td>13.3%</td>
<td>12.5%</td>
</tr>
<tr>
<td>40-49</td>
<td>20</td>
<td>15</td>
<td>29.9%</td>
<td>25%</td>
<td>31.3%</td>
</tr>
<tr>
<td>50-59</td>
<td>18</td>
<td>12</td>
<td>26.9%</td>
<td>33.3%</td>
<td>37.5%</td>
</tr>
<tr>
<td>60+</td>
<td>9</td>
<td>6</td>
<td>13.4%</td>
<td>33.3%</td>
<td>18.8%</td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
<td>51</td>
<td>100%</td>
<td>33.3%</td>
<td>23.9%</td>
</tr>
</tbody>
</table>

### Chiropractors subject to a final fitness to practice hearing

14 registrants were subject to a substantive PCC hearing in 2017.

<table>
<thead>
<tr>
<th>Male</th>
<th>12</th>
<th>86%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>2</td>
<td>14%</td>
</tr>
</tbody>
</table>

### Age range

<table>
<thead>
<tr>
<th>Age range</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>1</td>
<td>7%</td>
</tr>
<tr>
<td>30-39</td>
<td>1</td>
<td>7%</td>
</tr>
<tr>
<td>40-49</td>
<td>4</td>
<td>29%</td>
</tr>
<tr>
<td>50-59</td>
<td>5</td>
<td>36%</td>
</tr>
<tr>
<td>60+</td>
<td>3</td>
<td>21%</td>
</tr>
</tbody>
</table>
Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>9</td>
<td>64%</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>14%</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>7%</td>
</tr>
<tr>
<td>Black</td>
<td>1</td>
<td>7%</td>
</tr>
<tr>
<td>Mixed</td>
<td>1</td>
<td>7%</td>
</tr>
</tbody>
</table>

Complainants

In 2017 female complainants made 56% of all complaints while male complainants made 29% of all complaints.

Other means of referral or unknown referrers makes up 15% of complaints.

57% of complaints against male registrants are made by female complainants.
33% of complaints against male registrants are made by male complainants.
54% of complaints against female registrants are made by female complainants.
21% of complaints against female registrants are made by male complainants.

<table>
<thead>
<tr>
<th>Complainant</th>
<th>Male registant</th>
<th>Female registant</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>14 (33%)</td>
<td>5 (21%)</td>
<td>19</td>
<td>29%</td>
</tr>
<tr>
<td>Female</td>
<td>24 (57%)</td>
<td>13 (54%)</td>
<td>37</td>
<td>56%</td>
</tr>
<tr>
<td>Registrar</td>
<td>1 (2%)</td>
<td>3 (13%)</td>
<td>4</td>
<td>6%</td>
</tr>
<tr>
<td>Anonymous</td>
<td>3 (7%)</td>
<td>3 (13%)</td>
<td>6</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>42</strong></td>
<td><strong>24</strong></td>
<td><strong>66</strong></td>
<td></td>
</tr>
</tbody>
</table>
Test of Competence applicants

Chiropractors who wish to practise in the UK but hold chiropractic qualifications from outside the EU are required to take (and pass) our Test of Competence (TOC) before they can register. To pass the TOC, the applicant is required to demonstrate to a panel of chiropractors that they meet the requirements set out in the Education Standards.

In 2017, 34 people sat the TOC. There are three possible outcomes of the Test of Competence – ‘pass’, ‘fail’ and ‘further evidence required’ – which involves the applicant submitting additional written evidence of their skills and knowledge. In all instances where the applicant was required to provide further evidence they have subsequently passed.

We collect equality data on all applicants to ensure that our processes are fair and that there are no negative trends apparent.

**Sex**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Fail</th>
<th>Further Evidence</th>
<th>Pass</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>3</td>
<td>8</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
<td>3</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>11</td>
<td>16</td>
<td>34</td>
</tr>
</tbody>
</table>

**Age**

<table>
<thead>
<tr>
<th>Age group</th>
<th>Fail</th>
<th>Further Evidence</th>
<th>Pass</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 24</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>25-34</td>
<td>3</td>
<td>6</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>35-44</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>45-54</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>11</td>
<td>16</td>
<td>34</td>
</tr>
</tbody>
</table>

**Ethnicity**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Fail</th>
<th>Further Evidence</th>
<th>Pass</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>6</td>
<td>9</td>
<td>14</td>
<td>29</td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mixed</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>11</td>
<td>16</td>
<td>34</td>
</tr>
</tbody>
</table>
Religion or belief

<table>
<thead>
<tr>
<th>Religion or belief</th>
<th>Fail</th>
<th>Further Evidence</th>
<th>Pass</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>2</td>
<td>7</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>Hindu</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Muslim</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No religion</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>1</td>
<td></td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7</strong></td>
<td><strong>11</strong></td>
<td><strong>16</strong></td>
<td><strong>34</strong></td>
</tr>
</tbody>
</table>

Disability

Over 90% of applicants identified as not disabled.

Sexual Orientation

Over 90% of applicants identified as heterosexual.

Other protected characteristics

No data for gender reassignment, pregnancy and maternity and marital status.
Council, Committees and Assessors

Equality data pertaining to our Council and Committee members has been collected as part of recruitment processes and data gathering exercises to help increase our equality data.

Total members on each committee are as follows:

<table>
<thead>
<tr>
<th>Committee</th>
<th>Total members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Council</td>
<td>13</td>
</tr>
<tr>
<td>Audit Committee</td>
<td>5</td>
</tr>
<tr>
<td>Education Committee</td>
<td>9</td>
</tr>
<tr>
<td>Education Visitors</td>
<td>13</td>
</tr>
<tr>
<td>Test of Competence assessors</td>
<td>15</td>
</tr>
<tr>
<td>Professional Conduct Committee/Health Committee</td>
<td>16</td>
</tr>
<tr>
<td>Investigating Committee</td>
<td>19</td>
</tr>
<tr>
<td>Remuneration Committee</td>
<td>4</td>
</tr>
</tbody>
</table>

The Reappointments Committee and Registration Appeals Committee are subcommittees of the Council and each panel consists of interchangeable Council Members appointed for the purpose when required. As these Committees are subject to change we have not included it in the data the follows. Percentages are rounded up.

Where an individual sits as a member of Council and a Committee the equality data has been counted twice to provide a fuller picture about the overall make-up of members.

Where gaps appear (unknown) we will endeavour to work towards a more complete dataset in the coming year.

Sex

<table>
<thead>
<tr>
<th>Gender</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>56%</td>
</tr>
<tr>
<td>Female</td>
<td>44%</td>
</tr>
</tbody>
</table>

Age

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 - 29</td>
<td>0%</td>
</tr>
<tr>
<td>30 - 39</td>
<td>10%</td>
</tr>
<tr>
<td>40 - 49</td>
<td>21%</td>
</tr>
<tr>
<td>50 - 59</td>
<td>33%</td>
</tr>
<tr>
<td>60+</td>
<td>18%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>3%</td>
</tr>
<tr>
<td>Unknown</td>
<td>15%</td>
</tr>
</tbody>
</table>
Disability

<table>
<thead>
<tr>
<th>No</th>
<th>84%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>0%</td>
</tr>
<tr>
<td>Unknown</td>
<td>10%</td>
</tr>
</tbody>
</table>

Ethnicity

<table>
<thead>
<tr>
<th>White</th>
<th>77%</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME</td>
<td>6%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>3%</td>
</tr>
<tr>
<td>Unknown</td>
<td>14%</td>
</tr>
</tbody>
</table>

Sexual Orientation

<table>
<thead>
<tr>
<th>Heterosexual</th>
<th>45%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bisexual</td>
<td>0%</td>
</tr>
<tr>
<td>Gay or Lesbian</td>
<td>11%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>5%</td>
</tr>
<tr>
<td>Unknown</td>
<td>39%</td>
</tr>
</tbody>
</table>

Religion or belief

<table>
<thead>
<tr>
<th>No religion</th>
<th>30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>21%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
</tr>
<tr>
<td>Hindu</td>
<td>1%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>5%</td>
</tr>
<tr>
<td>Unknown</td>
<td>40%</td>
</tr>
</tbody>
</table>

Marital Status

<table>
<thead>
<tr>
<th>Married or in a civil partnership</th>
<th>40%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not married or in a civil partnership</td>
<td>12%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>4%</td>
</tr>
<tr>
<td>Unknown</td>
<td>44%</td>
</tr>
</tbody>
</table>

Other protected characteristics

24% identified their gender identity as not being different from the gender assigned at birth. We do not have data for the remaining 76%.

24% identified as not being pregnant at the time of response. We do not have data for the remaining 76%.
Staff

Due to there being only a small number of employees, we do not publish demographics on our Staff.