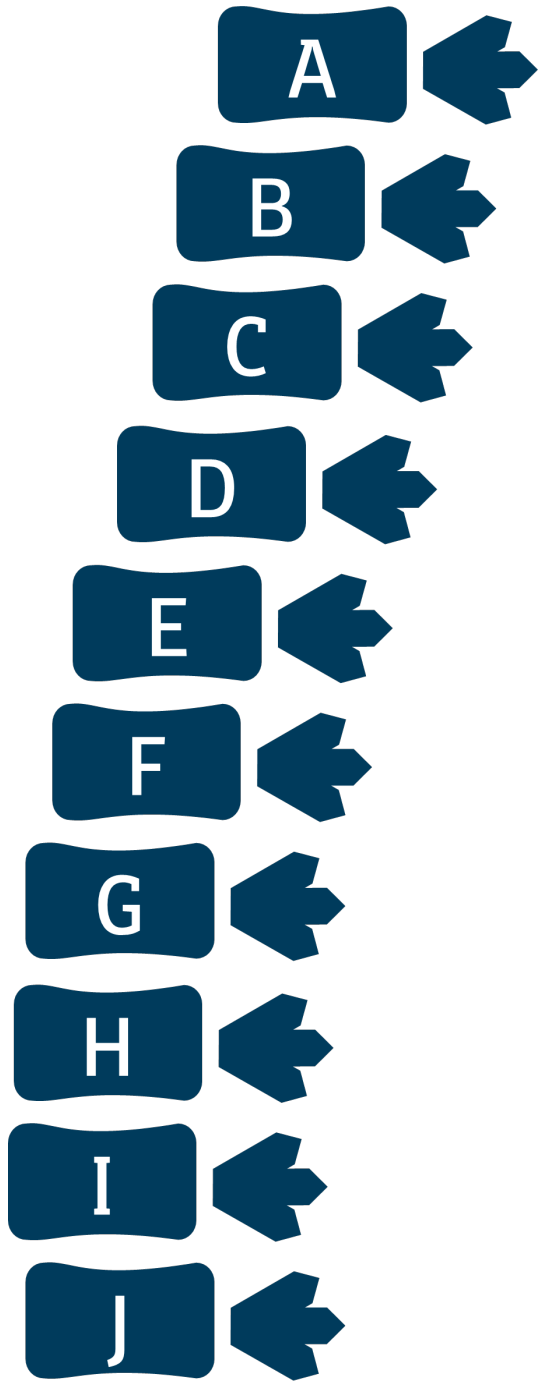
Response to Consultation

The General Chiropractic Council's consultation into the Code of Professional Practice:

The process of consultation and outline of resulting changes.



General Chiropractic Council

1. Introduction

1.1. This document is published alongside the final Code of Professional Practice and an independent thematic review of the consultation. These documents illustrate the process of developing the Code of Professional Practice, the consultation process and the changes made to the proposed version as a result of the consultation.

1.2. The document should be read alongside the Code of Professional Practice and the independent thematic review.

1.3. The GCC Code of Professional Practice encompasses both a Standard of Proficiency and Standards of Conduct and Practice for chiropractors. The GCC last consulted on the Code in 2015, with the Code coming into effect in 2016. Since then, the profession has evolved in response to changing patient expectations, and developments in wider healthcare.

2. Developing the Code of Professional Practice

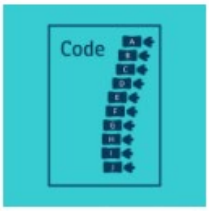
2.1. Timeline:

- **Autumn 2023. T**he GCC carried out the Code Scoping Review
- **December 2023.** Following the review, Council agreed to review the Code in 2024.
- **January 2024.** The scoping review was published and the intention to carry out a full review of the Code was announced publicly.
- **February 2024.** A survey of registrants identified the four values that underpinned their practice and were used to create a values based approach to the Code.
- **March 2024.** The values and Principles were agreed by Council.
- **April 2024.** The Code Conversation was launched. This used feedback to a blog, meetings with Council members and professional associations to inform three discussion events with the profession (held both online and in-person) throughout April and May.
- **June 2024.** Council considered and agreed to the proposals for the consultation and the Proposed Code of Professional Practice.
  The GCC also published two documents: **A summary of the Code Conversation** and **The independent report into the three registrant events** to illustrate how the Code Conversation had influenced thinking around the Code.
- **July 2024.** The Consultation went live on 22 July 2024.
- **September 2024.** The Consultation closed on 27 September 2024.
- **November 2024.** Thematic findings of the consultation discussed with Council.
- **December 2024.** The Code of Professional Practice, alongside this report and the independent thematic review of the consultation are considered by Council.

3. The Consultation

3.1. The GCC produced a number of documents and supporting documentation as part of the Code Consultation including:

- The Proposed Code of Professional Practice
- A Guide to the consultation
- The Equality Impact Assessment (including Welsh Language Impact Assessment)
- Glossary of terms within the Code of Professional Practice
- Mapping of the 2016 Code to the proposed Code of Professional Practice.



Proposed Code of Professional Practice


Consultation Guide


Equality Impact Assessment (including Welsh Language)

Glossary of Terms used

Mapping of 2016 Code to proposed Code

All of the documents were available online and a printable version was also produced.

3.2. The consultation was promoted in various ways, including:

- Emails sent to all stakeholders on the GCC's contact list, including those who responded to the Code Conversation.
- Emails were sent to all current registrants, and individuals applying for registration.
- Highlighting the consultation at existing meetings.
- Information on the main GCC website, including promotional material in the form of press releases, videos and social media posts to share.
- Encouraging chiropractors to ask their patients and colleagues to respond, and personalised letters were provided to them to assist with this.
- Encouraging education providers to ask their colleagues and students to respond, and personalised letters were provided to them to assist with this.
- Articles and information in the GCC newsletter.
- Information within the GCC email footer.

3.3. While respondents were encouraged to respond using the online questionnaire, they could also submit feedback by emailing or writing a freeform response, attending a consultation event or completing a hard copy feedback form.

3.4. The consultation materials and the online consultation questionnaire were made available in the Welsh Language.

3.5. Ten engagement events were held during the consultation period.

3.6. Seven discussion sessions with specific audiences were facilitated online by an external moderator, Gay Swait:

Date	Audience	Number of attendees
13/08/2024	Chair of Investigating Committee (IC)	1
15/08/2024	Education Providers	6
22/08/2024	Royal College of Chiropractors	3
11/09/2024	Chair of Professional Conduct Committee (PCC)	1
11/09/2024	Associations representing professional chiropractors (facilitated by GCC staff)	4
12/09/2024	Chiropractic expert witnesses	5
26/09/2024	Chiropractic expert witnesses – further session reconvened after first session for further discussion	4

3.7. Three evening consultation events for registrants were hosted by the Professional Associations. These were well attended online and took the form of a presentation from Nick Jones and Andrew Fielding, followed by a Q&A.

Date	Audience
25/07/2024	British Chiropractic Association
21/08/2024	UK Chiropractic Alliance (members of the MCA, SCA and UCA)
11/09/2024	UK Chiropractic Alliance (members of the MCA, SCA and UCA)

3.8. The online questionnaire ran from the 22 July until 27 September 2024.

3.9. The questionnaire comprised:

- Interest questions (to understand the respondent's relationship to the Code of Professional Practice)
- Three questions on each of the 10 Principles, with further opportunity to comment specifically on the Principle as a whole or on individual Standards
- Questions on the Glossary, and the Equality and Welsh Language Impact Assessment
- Demographic questions

- Two general questions at the end – on the consultation process, and on the Code of Professional Practice as a whole.

4. Responses to the Consultation

4.1. In total, 121 responses were received in response to the consultation:

Respondent self-reported description	Number of responses
Registered Chiropractors • Of which currently non-practising, or awaiting registration	79 3
Patient or member of the public • Of which have seen a chiropractor since January 2024	30 27
Work at an academic institute carrying out chiropractic education or research	2
Membership body, company, organisation, charity, regulator or governmental body	10

4.2. It should be noted that some individual chiropractors and representatives of stakeholder organisations attended discussion sessions or events, and also submitted a response to the survey. The professional association events were used by the professional associations to develop their responses.

4.3. The written responses comprised:

Submission route	Number of responses
Received via the online questionnaire	116
Received via freeform response	5

5. Analysis of the Consultation Response

5.1. It was important to consider the responses to the consultation both on an individual level (considering each suggested change on its own merits) and thematically (what were the themes emerging from the consultation as a whole).

5.2. Each comment received within the online questionnaire was manually categorised by the GCC:

i) Actionable Suggestion (a comment which suggested a change to a Standard or Principle)

ii) Positive (supportive of a Standard or Principle with no suggested change)

iii) Negative (opposed to a Standard or Principle with no suggested change)

iv) Neutral (comment too brief to be able to decide whether positive or negative)

5.3. Sentences within the freeform responses were assigned to Principles and Standards within the Code of Professional Practice, using the questionnaire as a guide, and then categorised in the same way.

5.4. In total there were 806 comments received across the 116 online questionnaire responses, and a further 219 relevant specific comments were extracted from the five freeform responses.

5.5. The GCC also searched the transcripts for quotes referencing specific Standards, and these quotes were extracted from the transcript and assigned to the Standard. A total of 320 relevant specific comments were extracted from the event transcripts. Where a quote referenced multiple Standards, it was assigned to multiple Standards.

6. The Thematic Review

6.1. The GCC commissioned Community Research, an independent research company, to consider the consultation responses and provide an independent report into the themes across the consultation.

6.2. To assist with writing their report Community Research were provided with:

i) Anonymised, but otherwise unprocessed, questionnaire data

ii) The free form text responses

iii) The categorised comments (with categories) from the questionnaire and the freeform text responses.

iv) Transcripts and, where available, recordings of the consultation events.

6.3. The independent report from Community Research identified 10 broad themes from the responses and is published separately.

6.4. The report was used to inform thinking around the Code of Professional Practice, and to highlight areas where further guidance from Council was required.

7. The Individual Principle and Standard Review

7.1. The GCC considered each Principle and Standard, alongside all the comments and quotes relevant to that Standard or Principle, and the findings of the thematic review. For each Standard the GCC considered if the Standard required any changes, and then the nature of any change.

7.2. The changes to individual Principles and Standards are set out in section 9.

8. Thematic Review Findings

8.1. The thematic review by Community Research identified 10 key themes across the consultation. These were:

- Positive Feedback
- Focus on Patient-centred care
- Minimum standards or aspirational approach
- Clarity over “must” and “should”
- Relationship to other healthcare standards
- Perceived narrowing of scope
- Legislative requirements
- Precision of language
- Use of the term “evidence based”
- Advertising and promotion.

Further information on these themes can be found in the Independent Report. Each of these themes is responded to below:

8.2. **Positive Feedback.**

We welcome the response to the consultation – both in terms of volume and quality of response. We welcome the feedback from respondents that they appreciate the values-based approach to the proposed Code of Professional Practice, and they recognise the amount of work put into the consultation.

8.3. **Focus on Patient-centred Care**.

We welcome the positive feedback from respondents to the importance of patient-centred care and person-centred care. We accept that there are a wide range of reasons for a person to seek chiropractic care, and in response we highlight that the definition of “patient” within the glossary is intended to cover all related terms that might be used such as client, customer or service user.

8.4. **Minimum standards or aspirational approach.**

We accept that there was some confusion as to whether the Code of Professional Practice represents a basic minimum Standard that chiropractors must adhere to. This was compounded by some of the publicity, the wording of one of the repeated questions in the consultation and some of the accompanying documents.

We also note that a high proportion of respondents agreed that the Standards within each Principle represent the “minimum Standards required to meet the Principle” suggesting that these were not aspirational.

This issue was discussed with Council and it was agreed that the Code of Professional Practice represents a **reasonable** expectation of chiropractors (which was the case for The Code (2016)). This is a higher level than a basic minimum Standard but is not aspirational.

During the review of the consultation each part of the Code of Professional Practice has been considered against a test of “reasonableness” and all references to “minimum” have been removed to ensure clarity.

Where a concern was raised in the comments that a specific Standard was aspirational, this has been carefully considered and a number of Standards have been reformulated as a result (details in 7.0 below).

We have moved a number of Standards from an action-based Standard to a knowledge-based Standard (“you must recognise…” or “you must understand”). This approach more closely reflects the Education Standards and lowers the expectation on the chiropractor.

8.5. **Clarity over “must” and “should”.**

We accept that the implied use of “must” (as opposed to an explicit “must”) impacted the clarity of the consultation document. In response all the Standards are now headed with the phrase: “As a chiropractor, you must:” and all Principles now begin with “You must”.

There was debate over whether to use “you should” within the Standards. As this suggests an aspiration, it was decided to be inappropriate, and so there is now only one use of “You should” within the Standards (referring to use of the Welsh Language in Standard G3).

Where some Standards were not absolute – and require a considered balance between the rights of the patient and other rights - they are now signalled by terms such as “you must consider” (E4) or “you must respect” (A4 and C8).

We acknowledge the comments that the Code of Professional Practice needs to be considered as a whole, particularly in relation to the overall burden on chiropractors and how the Code of Professional Practice will be used for Fitness to Practise allegations. In response, we have strengthened the explanation of the Fitness to Practise approach in the introduction, and highlight that an unintentional or minor breach of a Standard is unlikely to constitute unacceptable professional conduct:

“An unintentional or minor breach of a Standard is unlikely to constitute unacceptable professional conduct.”

The section headed “for patients” has been updated to encourage the patient to resolve complaints locally.

8.6. **Relationship to other healthcare standards.**

As a regulated healthcare profession (a member of a profession to which section 60(2) of the Health Act 1999 applies) it is right that chiropractors are held to a similar standard to that of registrants of the other healthcare regulators. In drafting the proposed Code of Professional Practice we sought

to pay due attention to the standards within the relevant codes of practice of other healthcare regulators, and apply them to chiropractic practice.

While we acknowledge the predominant “paid-for” model of chiropractic brings different challenges than practice within the NHS, we do not believe that this reduces the expectations of patients – if anything those are increased and there is a need for the Standards to highlight requirements which would be usual provision within the NHS.

We do not accept the suggestion that the Code of Professional Practice holds chiropractors to a higher level than other regulated professions – this does not consider the different legislation and models used by the other regulators (for instance the GMC Good Medical Practice document is able to specifically refer to guidance as part of their rules). In providing context to the Code of Professional Practice we recognise it will be important to make links with the codes of other professions.

We do, however, recognise some merit in the comments regarding the large number of Standards and Principles to adhere to. We have removed a number of Standards, which were felt to be duplicates, or were better combined. We have also removed some that were, on reflection, outside of the remit of the GCC (particularly within Principle J where the management of data is regulated by the Information Commissioners Office).

8.7. **Perceived narrowing of scope.**

The Code of Professional Practice has been drafted to apply to a much wider set of practice approaches than the previous 2016 Code – considering those working in education and research as well as a wide range of clinical roles. We welcome the feedback from the profession during the Code Conversation that helped us during the initial drafting stage.

We disagree that the Code of Professional Practice is intended to impose a narrower scope of practice onto the profession. This is not within the remit of the GCC, however we do highlight that each registrant must consider and understand their own individual scope of practice. The Code of Professional Practice has been updated to clarify this.

We disagree that the Code of Professional Practice prescribes how things are done. It is for each chiropractor, acting as an autonomous healthcare professional, to decide how to meet the requirements of each Standard.

We acknowledge there is a risk of an increase in complaints from registrants as the new obligations come into effect but will seek to mitigate this by setting expectations with guidance about when it is, and is not, appropriate to make a complaint about a colleague or fellow chiropractor.

We accept there was confusion about the use of the term “evidence”, and “evidence-based practice” and have worked to clarify these terms and ensure consistency (see 8.10 below).

8.8. **Legislative Requirements**.

We agree that there was a widespread misunderstanding of the scope of Standard C3 (now C4) concerning the responsibility to adhere to other regulations. Our intention was not to refer to other healthcare regulators, but instead sought to recognise that (because of the private healthcare business model), chiropractors were subject to regulation as a business as well as a professional. The Standard and glossary have both been updated to make it clearer that this refers to the Information Commissioners Office, the Advertising Standards Authority and other similar bodies.

We acknowledge there were concerns around the interaction of the Code with employment law (Principle H), and advertising and promotion regulation (Standards C3, C4 and C5). We have further elaborated on advertising and promotion below (8.11).

Principle H reflects the expectation of patients that healthcare professionals will encourage a positive working environment and allow all colleagues to concentrate on providing the best possible care. While this is a higher standard than that of employment legislation, it is also a reasonable standard considering the role and trust placed in the chiropractor as a professional. Principle H has also been clarified to consider more consistently who a chiropractor can reasonably be expected to have influence over.

8.9. **Precision of language**

We welcome the comments acknowledging efforts to ensure consistency of language, but accept that using consistent language and defining that appropriately is vital to the use of the document.

We have acted to distinguish and standardise terms, and use identical phrasing where we intend for an approach to be the same. These terms are then further defined in the glossary, to ensure consistency.

8.10. **Use of the term “evidence based”**

We agree that there was confusion within the proposal about the role of evidence within the Code of Professional Practice, with different terms used interchangeably. We acknowledge there is a lack of breadth and depth in chiropractic evidence in some areas due to the relatively young age of the profession, however we disagree that using “evidence informed” in place of “evidence-based” would help with the clarity of the expectation.

In response we have endeavoured to standardise and more clearly define aspects of evidence within the Code of Professional Practice.

Where appropriate, “evidence-based-practice” is used as a direct equivalent with “evidence-based medicine” as defined by Sackett et al. This definition is only used where specifically related to the provision of care and requires the

practitioner to combine published evidence with personal experience and patient preference.

Where the Standard defines evidence for a specific technique or action, (for instance when prioritising diagnostic tests) it is confusing to refer to “evidence-based” so the term “best quality of evidence that is available at the time” is used consistently. The definition of this term within the glossary recognises that the evidence base is constantly developing, and there is a range of quality of evidence.

8.11. **Advertising and promotion**

Although we acknowledge the clarity that Standard B3 in the 2016 Code gave to registrants about advertising and promotion, it was restrictive (by referring only to advertising it could be read to exclude other promotional activity such as online reviews) and dependent on the interpretation of a Standard set by another regulator.

The profession has demonstrated its ability to adhere to both the ASA standards and the GCC guidance on advertising, and the Code of Professional Practice does not seek to change the expectations regarding advertising and promotion.

The requirement to adhere to the ASA code is captured by Standard C4, and C5 and C6 reinforce the expectations of the previous guidance by bringing other promotional activity within the Code of Professional Practice itself. The guidance will be reviewed in light of new practices, but the expectations on the profession are expected to remain the same.

We acknowledge that the ASA code contains a stricter definition of evidence than is used elsewhere in the GCC Code of Professional Practice. This is entirely appropriate as, at the point of a prospective patient seeing an advertisement, the chiropractor is not able to apply their own experience or the preference of the patient to patients’ individual circumstances.

9. Response to the Individual Principle and Standard Review

9.1. Each Principle and Standard was considered individually alongside the thematic review and the comments specific to that particular Standard.

9.2. Where changes were made to a Standard they are set out in the tables below. It is important to note that some Standards have been re-numbered in the final Code of Professional Practice, and so the table contains both the reference in the final document, and the reference in the consulted document.

9.3. Definitions of change types in order of increasing level of change

	Definition of change
No change	The wording of the Standard is unchanged other than, in some cases, the addition of “You must” at the start of subsequent sentences within the Standard.
Text reordered for clarity	The meaning of the Standard is unchanged, but there may be changes in punctuation, sentence order or word order to aid clarity.
Re-worded for clarity following feedback	The meaning of the Standard is unchanged but, alongside changes in punctuation, sentence order or word order there may be synonyms introduced for consistency, or to aid clarity.
Content changes following feedback	There is a change of meaning, scope or approach within the Standard that means it has a different interpretation (often very slight) to the Standard originally proposed. Where this is the case, the change is described.
Standard removed	A consulted upon Standard has been removed. Where this is the case, the reason is explained.

9.4. The Standards that are considered to be Standards of Proficiency are marked with a tick in the column marked SOP.

9.5. **Principle A: You must put the interests of patients first**

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
A1	put the patient's needs and safety at the centre of their care.	A1	No change.	✓
A2	show respect, compassion and care for the patient. You must find out what matters to them and consider their needs and preferences. You must respond honestly and openly to their questions and must not pressure the patient to accept your advice.	A2	Content changes following feedback: *"Ask" replaced by "find out what matters" to reflect alternative approaches to conversation. "Any" pressure was removed to better reflect the need to persuade and influence patients.*	✓
A3	provide care based upon the principles of a person-centred approach by: i. engaging effectively with the patient through individualised conversations and interactions; ii. enabling and supporting the patient in their care, health and wellbeing; iii. involving the patient in decisions about their care; iv. collaboratively supporting and managing the patient when they have a high complexity of physical, psychological and social factors.	A3 A4 A5	Content changes following feedback: *This Standard amalgamates the consulted Standards of A3, A4 and A5 to better represent the principles of person-centred care and more closely reflect the Education Standards.* *Subsequent Standards have been renumbered.*	✓
A4	respect the patient's privacy, dignity and their right to choose who is present when their care is discussed and provided.	A6	Content changes following feedback: *The word "in the room" was replaced with "present" to account for provision in sports environments.* *The word "respect" highlights that the right is not absolute - the chiropractor must consider the needs and rights of the patient and balance it with the rights of the chiropractor to see a patient alone or in the presence of a chaperone.* *The addition of "and discussed" makes it clearer that this applies across the whole appointment.*	✓

A5	treat the patient fairly and without discrimination, interacting in a way that respects their choices, diversity and culture.	A7	Text reordered for clarity.	✓
A6	safeguard children and vulnerable adults by: • considering their safety and welfare; • assessing their vulnerability; • actively looking for signs of abuse. When you suspect a child or vulnerable adult could be at risk of, or suffering, abuse or neglect, you must promptly follow the established local safeguarding arrangements to report your concern. You must record your suspicions and actions.	A8	Text reordered for clarity.	✓

9.6. **Principle B: You must ensure safety and quality in clinical practice**

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
B1	protect patients by promoting and maintaining a culture of safety, seeking to prevent harm before it occurs.	B1	Re-worded for clarity following feedback.	✓
B2	act promptly and appropriately when you have concerns about the safety of a patient, and record what you did.	B2	Text reordered for clarity.	✓
B3	practise in a safe, hygienic environment where you actively identify and control risks. You must ensure all equipment you use is safe and meets relevant safety standards. You must plan for first aid and other emergencies.	B3	Content changes following feedback: *Changed "regulatory standards" to safety standards. Have added First aid, and removed the requirement to follow the procedures as this is self-evident.*	✓
B4	recognise safety incidents that risk the safety of a patient or another person, or have the potential to do so ("near miss"). You must understand the importance of reporting incidents through a suitable safety system, so that you, and the wider profession, can learn from them.	B5	Content changes following feedback: *The Standard has been changed from an action-based Standard ("report") to a knowledge-based Standard ("understand"). It has been reworded to define "near miss" within the text. It has been moved to be closer to similar Standards.*	✓
B5	recognise the importance of promoting accessible healthcare for all patients, and recognise how this can be supported in your practise.	B4	Content changes following feedback: *The Standard has been changed from an action-based Standard ("support") to a knowledge-based Standard ("recognise").*	✓
B6	collect, evaluate and use feedback and data about the quality of care of patients to continuously improve your practise.	B6	Re-worded for clarity following feedback.	✓

9.7. **Principle C: You must act with honesty, and integrity, and maintain the highest standards of professional and personal conduct**

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
C1	look after your health and wellbeing, seeking support when necessary. You must protect others from harm caused by the health, conduct or performance of you or any other regulated healthcare professional.	C1	Text reordered for clarity.	✓
C2	seek appropriate independent advice if you have significant concerns about your own fitness to practise, whether due to issues with health, character, behaviour, judgement or any other matter which may compromise the safety of patients or damage the reputation of your profession.	C14	Content changes following feedback: *"stop practising immediately" changed to "seek appropriate independent advice" to be more proportionate. The Standard moved to reflect similar themes with C1.*	
C3	have appropriate insurance and indemnity cover for the full scope of your own individual practice. You must be clear with the patient that you are registered with the General Chiropractic Council. You must be clear with the patient whether each person you employ, manage or lead that has a chiropractic qualification, is (or is not) registered with the GCC or another statutory UK health regulator.	C2	Content changes following feedback: *Clarification over the people in a workplace that a chiropractor can reasonably be expected to have influence over - "employ, manage or lead" defined in glossary.*	
C4	take responsibility, as an autonomous healthcare professional, for keeping up to date with, and following relevant legislation, regulations, codes of practice and GCC guidance.	C3	Re-worded for clarity following feedback.	✓
C5	when telling people about your services, ensure that all information is factual, verifiable, does not mislead, or exploit their vulnerability or lack of health knowledge. Where you delegate this, the accountability sits with you.	C4	Content changes following feedback: *Clarity that Chiropractor is accountable for all information about their service – even when this is delegated to another.*	✓

C6	ensure health information you share publicly is consistent with the best quality of evidence that is available at the time, and is credible and accessible to the intended audience.	C5	Re-worded for clarity following feedback.	✓
C7	ensure your behaviour is professional at all times, upholding and protecting the reputation of the profession and justifying public trust.	C6	Re-worded for clarity following feedback.	
C8	respect patient confidentiality, and dignity, at all times including online, during remote consultations, and when referring to patients anonymously.	C7	Content changes following feedback: *Changed "maintain" to "respect" to account for occasions where there may be a lawful basis to disclose information.*	✓
C9	be honest, fair, and transparent in your business. Your clinical judgement must not be prejudiced by any personal, financial or commercial interest. You must not ask for, accept, or offer, any inducement that may prejudice the care of a patient.	C8	Content changes following feedback: *"Detrimentally affect" replaced by "prejudice". "Recommendations and care" replaced by "clinical judgement".*	
C10	determine and share a clinical plan of care for the patient separately (and independently) from any financial payment plan. You must provide a clear contract for any financial payment plan which must include arrangements for refunds for unused care. You must not offer a financial payment plan that extends beyond the amount of care set out in your initial clinical plan of care for the patient. You must not pressure the patient to commit financially to long term treatment.	C9	Text reordered for clarity.	
C11	fulfil the duty of candour by being open and honest with the patient. Inform them if something goes wrong with their care which causes, or could cause, harm or distress. You must offer an apology, a suitable remedy or support, and an explanation of resulting actions.	C10	No change.	✓

C12	ensure your personal biases, values and beliefs do not prejudice the care that you provide to the patient, your personal interactions, or your professional reputation.	C11	Re-worded for clarity following feedback.	✓
C13	promote equality, diversity and inclusion, challenge discrimination and seek to tackle inequalities. You must raise concerns about colleagues if you believe they are treating people unfairly, have discriminated against someone or if their personal biases have prejudiced the care they provide. When raising concerns you must follow the relevant local procedures to maintain the safety of everyone involved.	C12	Content changes following feedback: *Further duty to promote equality added.* *“Detrimentally affect" replaced by "prejudice".* *“Prejudice” and “Relevant local procedures” defined within the glossary.*	✓
C14	have a reasonable justification for refusing or discontinuing care for a patient. You must record this. You must explain how they can find other healthcare professionals who could offer care, in a fair and unbiased way.	C13	Content changes following feedback: *"Do not unreasonably deny care" has been removed but a reasonable justification must be recorded. The duty to explain how to find other suitable care remains.*	✓
C15	promptly inform the GCC if, anywhere in the world: i. you are charged with a criminal offence; ii. you are convicted of a criminal offence; iii. you are the subject of a regulatory investigation; iv. you are suspended, dismissed, refused membership or placed under a practice restriction following concerns about your professional conduct or competence by another organisation (including regulator, insurer, professional body, employer).	C15	No change.	

C16	cooperate promptly and fully with any formal investigation, inquiry, or complaints procedure into your own professional conduct or performance, that of others or the care of a patient. You must respond to all reasonable requests from the GCC. If you are informed that you are the subject of a GCC investigation, you must follow any reasonable directions you are given by the GCC to assist in a fair and efficient process.	C16	Re-worded for clarity following feedback.	

9.8. **Principle D: You must provide a good standard of clinical care and professional practice**

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
Clinical assessment and diagnosis or rationale for care				
D1	take and record a thorough case history for the patient.	D1	Text reordered for clarity.	✓
D2	find out the patient's goals for their care. Before commencing care, you must establish planned health outcomes of the care, using recognised outcome measures. You must agree with the patient (and record) how progress towards the planned health outcomes will be measured.	D2	Re-worded for clarity following feedback.	✓
D3	with the valid consent of the patient, carry out an appropriate physical examination, prioritising methods supported by the best quality of evidence that is available at the time. You must explain to the patient (and record) the results of the examination.	D3	Content changes following feedback: *Physical examination now requires valid consent. "Using" replaced by "prioritising" to account for variable levels of evidence for techniques. Clarification of "best available evidence that is available at the time". Results of the examination need to be explained, not "fully" explained.*	✓
D4	ensure that you have the valid consent of the patient for any diagnostic investigation (including imaging) before it is carried out. You must carry out investigation in the health interests of the patient and in a way that minimises the risks to them. You must base the investigation on clinical reasoning, following authoritative evidence-based guidelines and adhering to all regulatory standards.	D4	Re-worded for clarity following feedback.	✓
D5	use the results of your clinical assessment of the patient to arrive at a working diagnosis or rationale for care which you must record and keep under review. You must keep the patient informed, including about any diagnostic uncertainty.	D5	Re-worded for clarity following feedback.	✓

Developing a plan of care				
D6	use the findings of the clinical assessment and the best quality of evidence that is available at the time, to propose (and record) a plan of care for the patient. You must tell the patient where your proposals are not supported by evidence of accepted quality and record your rationale and discussions.	D6	Content changes following feedback: *D6, D7 and D8 have been rewritten to separate the aspects of proposing care, patient understanding of the proposal and then agreeing the care.* *The patient's views is removed from the proposal of the plan of care - that will be taken into consideration once the plan of care is shared with the patient.*	✓
D7	inform the patient of the risks and benefits to the proposed plan of care. You must inform them of alternatives to the proposed plan of care including evidence-based options that may be provided by other healthcare professionals, and the expected natural history (prognosis without any care).	D7	Content changes following feedback: *D6, D7 and D8 have been rewritten to separate the aspects of proposing care, patient understanding of the proposal and then agreeing the care.* *This Standard was re-worded to clarify that the risks and benefits of the proposed care is a separate point of discussion to the alternatives to the proposed plan of care.*	✓
D8	apply evidence-based practice to develop, implement and record a personalised plan of care, in partnership with the patient. You must record and explain to the patient how progress towards the planned health outcomes of the care will be evaluated and set timescales. You must obtain and record the valid consent of the patient before implementing the plan of care. You must not propose a plan of care that is excessive or that is not justified by a robust, recorded clinical assessment.	D8	Content changes following feedback: *D6, D7 and D8 have been rewritten to separate the aspects of proposing care, patient understanding of the proposal and then agreeing the care.* *This Standard was rewritten to clarify the requirement for evidence-based practice.* *Reassessment was removed from this Standard as it was a repeat of D9.*	✓

Evaluating and modifying the plan of care				
D9	continuously monitor and record the patient's progress towards their planned health outcomes, evaluating and adapting the plan of care to meet their needs. You must carry out formal clinical reassessments at regular intervals, using recognised outcome measures to evaluate the effectiveness of care, as previously agreed with the patient and set out in their plan of care.	D9	Re-worded for clarity following feedback.	✓
D10	discuss with the patient their progression towards their planned health outcomes, agree any continuation or modification to their plan of care and record valid consent.	D10	Re-worded for clarity following feedback.	✓
Providing care				
D11	use evidence-based practice to select and implement safe, appropriate, care that meets the needs and preferences of the patient. This could include: • manual techniques; • rehabilitative interventions; • psychologically informed approaches; • education and advice. You must encourage and support patients to self-manage their health, signposting them to relevant resources.	D11	Content changes following feedback: *"This may include" was not meant as permission, but was interpreted as such. Changed to "this could include" to highlight examples only.* *"education and advice" is added.*	✓
D12	with the valid consent of the patient make, receive and implement effective referrals to other healthcare professionals, in the best interest of the patient.	D12	Text reordered for clarity.	✓

D13	engage in evidence-based interventions that support prevention and health promotion, considering health inequalities, for the benefit of the patient and population health.	D13	Content changes following feedback: *The Standard retains a duty to use health interventions to benefit patient and population health within daily practice.* *"Support public health initiatives" was removed following feedback that it could be interpreted to compel a chiropractor to promote initiatives outside their knowledge. The alternative reading ("support" as in "do not undermine") is adequately covered by C5 and C6.*	✓
D14	understand the risks and benefits to the patient before using any new technology and ensure that clinical care is safe and effective, whether it is provided face-to-face or remotely. You must obtain the valid consent of the patient.	D14	Re-worded for clarity following feedback.	✓
D15	ensure that in promoting or conducting research or using research in practice, you do so ethically and effectively.	D15	Re-worded for clarity following feedback.	✓

9.9. **Principle E: You must establish and maintain clear professional boundaries**

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
E1	recognise the power imbalances that come with being a healthcare professional. You must not abuse the position of power and trust which you occupy as a professional. You must not pursue or encourage improper financial, emotional or personal relationships. You must not cross any professional boundary: this includes sexual boundaries.	E1	Content changes following feedback: *The proposed Standard was widened to encompass all power imbalances – not only with patients. It also recognises that the imbalance may not be in the chiropractor's favour. This Principle will be subject to further guidance.*	✓
E2	ensure you, and any person you employ, manage or lead, treat all patients, their carers or others accompanying them, with respect and dignity.	E2	Content changes following feedback: *Clarification over the people in a workplace that a chiropractor can reasonably be expected to have influence over - "employ, manage or lead" defined in glossary.*	
E3	explain the reason to the patient and obtain and record valid consent if there is a clinical need for clothing to be removed. You must respect their right to privacy to undress and you must offer the use of a gown. You must always obtain a patient's consent if it becomes necessary during examination or treatment for an item of the patient's clothing to be adjusted.	E3	Re-worded for clarity following feedback.	✓
E4	consider the need for (or advisability of) another person to be present to act as a chaperone or advocate - for your own protection and that of the patient. You must, wherever possible, offer a chaperone if the clinical assessment or care might be considered intimate or where the patient is a child or a vulnerable adult, or where the patient requests one. You must record when you offer or use a chaperone or advocate.	E4	Re-worded for clarity following feedback.	✓

9.10. **Principle F: You must obtain appropriate, valid consent from patients**

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
F1	give the patient necessary, accurate, relevant and clear information in a format that is accessible to them so they can make informed decisions about their health needs and care options. You must take reasonable steps to check that they understand the information given to them.	F1	Content changes following feedback: *Addition of the word "necessary" to enable the information provided to support the concept of valid consent.*	✓
F2	give due regard to the capacity of the patient to give valid consent, considering that their capacity can change over time.	F2	Text reordered for clarity.	✓
F3	ensure the consent of the patient is voluntarily given, without pressure, or undue influence.	F4	No change. *However, the Standard has been moved so that Standards F1 to F3 reflect the necessary tenets of valid consent.*	✓
F4	obtain, and record, valid consent from a patient (or their valid authority) before: • commencing or amending assessment or care; • involving them in teaching or research; • making a recording of them; • disclosing identifiable information about them (unless there is another lawful basis to do so). Consent is a continuous process, and you must make ongoing checks that consent continues to be given.	F3	No Change	✓
F5	take particular care to obtain valid consent when seeing a child or vulnerable adult, considering if the patient is legally competent to give consent or requires the consent of a parent or valid authority.	F5	Re-worded for clarity following feedback.	✓

9.11. **Principle G: You must communicate professionally, properly, and effectively**

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
G1	take reasonable steps to understand and meet the language and communication needs and preferences of the patient, while maintaining their privacy.	G1	No change.	✓
G2	communicate clinical information to the patient clearly, sensitively and effectively. You must use language that enhances the care of the patient, promotes their health literacy, and supports shared decision-making.	G2	No change.	✓
G3	have visible and easy to understand information for the patient on fees, charging policies and how to make a complaint. This information must include the patient's right to change their mind about their care and their right to refer any unresolved complaints to the GCC. You must respond promptly and appropriately to any complaints that arise. If you practise in Wales, you should consider also making information available in the Welsh language.	G3	Text reordered for clarity.	✓
G4	communicate effectively with other professionals in the interest of meeting the patient's health and care needs and goals. You must only share information with the consent of the patient (unless there is another lawful basis to do so).	G4	Content changes following feedback: *The proposed Standard was updated to highlight there were other lawful basis for sharing information in the interest of meeting the patient's health and care needs (for instance if there is a concern for the safety of the patient).*	✓

G5	tell the patient who is responsible for their care. When arranging for another person to provide their care, you must be clear with the patient: • whether that person is registered with a statutory UK health regulator; • who holds accountability for that care.	G5	Content changes following feedback: *The Standard has been clarified to highlight the two relevant details to the patient when being offered delegated or referred care – whether the individual is registered with a statutory UK health regulator, and who is accountable for the care provided.*	
G6	when communicating online as a healthcare professional (including media sharing, social networking sites and user-generated content), do so responsibly. You must check that information is not misleading, and maintain professional boundaries and public confidence in the profession. Where you delegate this, the accountability sits with you.	G6	Re-worded for clarity following feedback.	✓

9.12. Principle H: You must foster collaborative healthcare, effective professional relationships and safe, supportive workplace practice

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
H1	collaborate appropriately and effectively with other health and care professionals, to enhance the integrated care of patients.	H1	Content changes following feedback: *"appropriately" added to allow for wider range of practice approaches.*	✓
H2	delegate tasks or duties only if safe and appropriate to do so. You must ensure that the person you delegate to is qualified, competent, and supervised and supported as necessary.	H2	No change.	✓
H3	demonstrate effective team working and professional interpersonal relationships as required by your role. This includes contributing to the design, delivery, and improvement of healthcare services.	H3	Re-worded for clarity following feedback.	✓
Your professional responsibility towards colleagues				
H4	demonstrate leadership appropriate to a healthcare professional and to your role.	H4	Re-worded for clarity following feedback.	✓
H5	treat others in the workplace fairly and with respect. You must report, follow-up and escalate concerns, following relevant procedures in your workplace, if you become aware of bullying, harassment, or intimidation. You must act quickly and appropriately where such concerns are raised to you, keeping everyone involved safe. You must encourage and support colleagues to raise their concerns.	H5	Content changes following feedback: *Reworded for consistent approach with H6 around reporting requirements, and clarity that this applies within a workplace.*	

H6	report, follow-up and escalate concerns, following relevant procedures in your workplace, where the performance or conduct of colleagues puts others at risk of harm. You must act quickly and appropriately where such concerns are raised to you. You must encourage and support colleagues to raise their concerns.	H6	Content changes following feedback: *Clarity that this applies within a workplace.*	
H7	be prepared, as necessary, to contribute to mentoring, teaching, training and professional development of students and other colleagues. You must allow any person you employ, manage or lead to meet their regulatory requirements.	H7	Content changes following feedback: *Added "as necessary". Clarification over the people in a workplace that a chiropractor can reasonably be expected to have influence over - "employ, manage or lead" defined in glossary.*	✓

9.13. **Principle I: You must maintain, develop and work within your professional knowledge and skills**

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
I1	engage in reflective practice, seeking feedback and analysing information about your practice and the care that you provide, in the interests of supporting continuous improvement.	I1	Re-worded for clarity following feedback.	✓
I2	regularly consider how to adapt or improve your practice considering new developments, technologies and evidence from research.	I2	No change.	✓
I3	routinely seek and critically appraise emerging evidence. You must integrate findings of the best quality evidence available at the time into your practice, to enhance the care of patients.	I3	No change.	✓
I4	maintain and develop your competence and performance, taking part in relevant and regular learning and professional development activities. You must be competent in all aspects of your professional work, including in any formal leadership, management, research or teaching role.	I4	No change.	✓
I5	recognise and work within the limits of your own knowledge, skills and competence. You must be clear with the patient about your limits.	I5	No change.	✓
I6	recognise the roles and expertise of other chiropractors and healthcare professionals. You must refer to them, or seek their expertise, when needed.	I6	No change.	✓
I7	not allow another person you employ, manage or lead to take on responsibility for the clinical assessment or care of a patient where it is beyond their level of knowledge, skills, or experience.	I7	Content changes following feedback: *Clarification over the people in a workplace that a chiropractor can reasonably be expected to have influence over - "employ, manage or lead" defined in glossary.*	

9.14. **Principle J: You must maintain and protect information about patients**

Final	Final Standard	Draft	Summary of changes made (see description)	SOP
J1	adapt to advancing technology, including data sharing, media sharing and social media, to proactively protect the patient's personal information.	J1	Content changes following feedback: *The first two clauses of the proposed Standard are removed as they are covered by data protection legislation. The third sentence remains unchanged.*	✓
J2	be accountable for keeping patient records up to date, legible, and attributable. Your record must accurately represent each interaction with the patient. Retrospective amendments or additions to patient records must be identified clearly.	J3	Content changes following feedback: *"Accountable" added to reflect the ultimate responsibility for patient records rests with the chiropractor even if someone else (or AI) is writing on their behalf. Record must now "accurately" represent each interaction.*	✓
J3	store patient records safely, and securely (whether physically or digitally) so that they remain in good condition for an appropriate retention period (accounting for the age of the patient and when they were last seen).	J4	Content changes following feedback: *Following legal advice the appropriate retention period is not "described in law".*	
J4	have documented arrangements in place to protect or transfer patient records in case of moving clinic, ceasing practise or in the event of your death.	J5	Content changes following feedback: *The arrangements now need to be "documented".*	
J5	ensure that patient records remain your responsibility, even where a patient has moved, unless you have contractually transferred this responsibility to another healthcare professional or organisation.	J6	No change.	
		J2, J7	Standard removed. *These Standards were wholly covered by data protection legislation*	

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