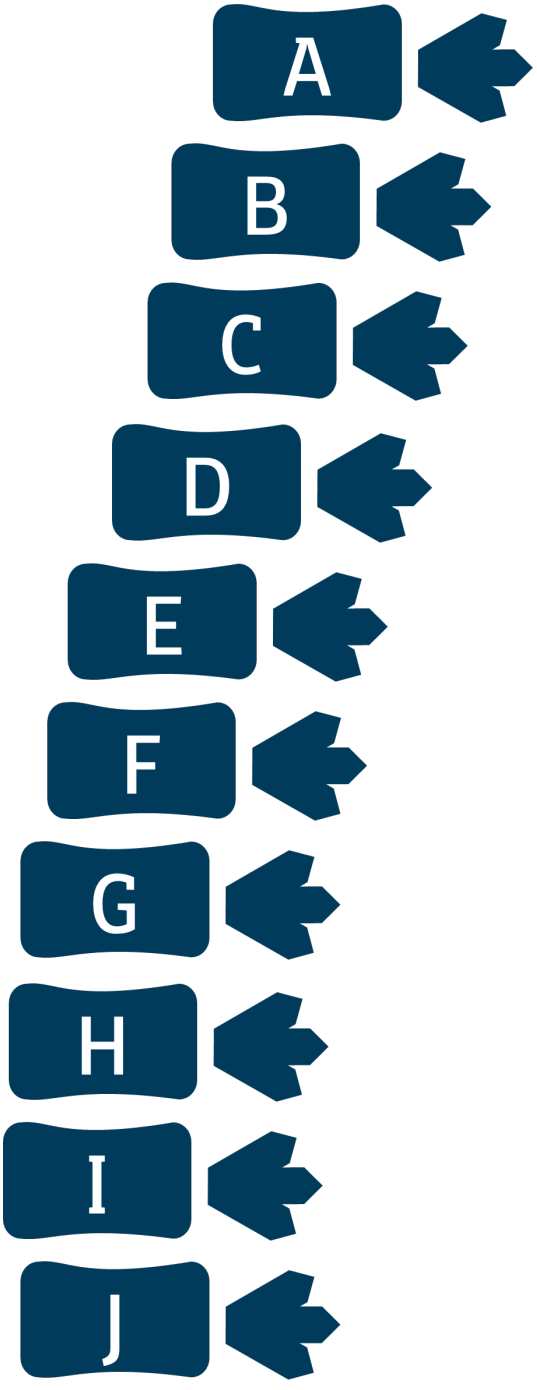
Code of Professional Practice:

How the Code of Professional Practice relates to the Code (2016)

Published by General Chiropractic Council
to support the Code of Professional Practice



This document maps the changes between the Code (2016) and the Code of Professional Practice.

Contents

Principle A
You must put the interests of patients first

Code 2016:	*Principle A:* *Put the health interests of patients first.*
What has changed?	The removal of 'health' broadens Principle A.
Why has this change been made?	This recognises and better reflects that patient interests extend beyond their health interests (for example, also including their dignity, privacy and being treated fairly).

Introduction to Principle A:

The interests of the patient come first, making the care and safety of every patient the priority. The chiropractor's duty of care towards them is fulfilled by promoting their safety and wellbeing, treating them fairly and with respect, and acting to safeguard them. Providing patient-centred care enables their interests to be met. This means listening to each patient, helping them to be involved in reaching decisions about their care, providing care that is personalised to their needs and empowering them in their care, health and wellbeing.

What has changed?	The introduction to Principle A sets out how it represents core shared values: **Patient-Centred Care; Safety And Quality.**

A1	put the patient's needs and safety at the centre of their care	
Code 2016:	**A5**	*prioritise patients' health and welfare at all times when carrying out assessments, making referrals or providing or arranging care. Respect a patient's right for a second opinion..*
What has changed?	We have rephrased A5 to provide a broader standard as the foundation to Principle A	
Why has this change been made?	All of our stakeholders identified patient-centred care as a key value. For registrants, this was their most important value. The amendment signals the need for every aspect of the care process to be person-centred and in the best interest of the patient. The amendment updates the Code in line with input from patients and registrants.	

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.	
Code 2016:	**A1**	*show respect, compassion and care for your patients by listening to them and acknowledging their views and decisions. You must not put any pressure on a patient to accept your advice*

What has changed?	We have made linguistic changes that emphasise the need for you to actively seek information from the patient. ‘Views and decisions' is changed to 'needs and preferences', to better reflect the principles of person-centred care. The new inclusion of 'responding honestly and openly' means that the patient can weigh up advice, underpinning patient autonomy and shared-decision making.
Why has this change been made?	These amendments update the Code of Professional Practice in line with other regulators and with input that patients gave us.

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.
Code 2016:	*New standard*
What has changed?	The new standard (A3) sets out the main steps of patient-centred care, as defined in Person-centred Approaches (2017). This sets out: i. a new requirement - ensuring that every patient is treated as an individual throughout their care ii. a new requirement, concerned with empowering the patient. iii. a specific requirement to implement shared decision-making iv. a new requirement to make sure that you work effectively with whoever else you need to, playing your part to make sure that a patient's various health and care needs are integrated and delivered well.

Why has this change been made?	Patient-centred care is a core shared value between patients and chiropractors. The Code (2016) pre-dated clear definitions of patient-centred care. Our stakeholders (including patients and registrants) told us that this was under-represented and/or needed to be prioritised. Patients told us that they wanted to be treated as individuals. This is a key element of person-centred approaches, that underpin patient-centred care. Patients also told us that they wanted to be given agency in determining their care. They also valued care that empowered them to help themselves. The GCCs Public Perceptions research (2021) found that patients valued having an active role (e.g. receiving exercises and self-management advice), that enables them to take control of their conditions. A further finding of the Public Perceptions research was that patients want to have an active role in the decisions around their treatment. Shared decision-making was also identified by our stakeholders as important and somewhat, but not fully reflected in the Code (2016). Patients told us that they expected that their chiropractor would work with others who are involved in their care. Collaborative practice was not included in the Code (2016). These amendments update the Code of Professional Practice in line with best practice developments in healthcare (person-centred approaches), the professional standards of other regulators, and with our research and what stakeholders told us.
See also:	• Skills for Health - person centred approaches https://www.skillsforhealth.org.uk/resources/person-centred-approaches-2017/ • NICE Guidance – shared decision making: https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making • GCC Public Perceptions Report 2021: https://www.gcc-uk.org/assets/downloads/Public_Perceptions_Research_report,_February_2021.pdf

A4	respect the patient's privacy, dignity and their right to choose who is present when their care is discussed and provided.
Code 2016:	**A2** *respect patients' privacy, dignity and cultural differences and their rights prescribed by law.*
What has changed?	Respecting cultural differences has been moved to A5 Respecting patients rights prescribed by law has been removed (it is captured in A5 and C3) The right of the patient to choose who is present when their care is provided is added, with respect to maintaining privacy and dignity.
Why has this change been made?	Amendments reduce duplication within the Code of Professional Practice. The right to choose who is present when their care is provided is introduced to ensure that the preference of the patient is fully considered, respected and upheld within whatever style of care delivery environment you are working. This follows discussions that we had with you at Code Conversation workshops.

A5	treat the patient fairly and without discrimination, interacting in a way that respects their choices, diversity and culture.	
Code 2016:	**A4**	*treat patients fairly and without discrimination and recognise diversity and individual choice.*
What has changed?	'Recognise diversity' has been replaced with 'interacting in a way that respects....diversity'	
Why has this change been made?	This amendment places a better focus on actions, as opposed to attitudes. This meets the expectations of stakeholders, who told us that EDI considerations were important and could be further strengthened.	

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.	
Code 2016:	**A7**	*safeguard the safety and welfare of children and vulnerable adults. As a professional, you must fulfil your legal obligations if you suspect that a child or vulnerable adult is at risk from abuse or neglect by following established local procedures for reporting that suspicion.*
What has changed?	The Code (2016) standard requires you to fulfil legal obligations and to report safeguarding concerns. The amendments strengthen your duties around safeguarding by emphasising that you also have active responsibilities to assess whether a patient is vulnerable and to look for signs of abuse. The revisions also specify that you must act 'promptly' where you have concerns and that you record safeguarding issues. The requirement to 'fulfil your legal obligations' has been removed, to reduce duplication, as this is captured within C3.	
Why has this change been made?	This amendment is in line with the strengthened expectations of healthcare professionals more widely, in the interest of protecting children and vulnerable adults.	

Principle B
You must ensure safety and quality in clinical practice

Code 2016:	*Principle B is new*
What has changed?	This is a new Principle, focussed on practice systems that ensure quality, safety and accessibility. It is about practice governance. Some Standards in the Code (2016) that address aspects of practice safety have been imported to new Principle B, as they sit better within it (A3, A6, C9). B1, B4, B5 and B6 are new Standards.
Why has this change been made?	This is a new Principle, introduced to address areas identified by our stakeholders as key gaps in the Code (2016). Safety in healthcare and also in chiropractic are global priorities of the WHO and the WFC. The new Education Standards already include these as required outcomes of undergraduate education. With respect to safety, preventing adverse events associated with caring for the patient is captured within Principle D (setting out the necessary clinical processes to keep each individual patient safe). Principle B, in contrast, is concerned with the wider good clinical and practice governance, that provides a safe setting for the care of patients and fosters a culture of safety. This brings the requirements in line with those of other healthcare professionals, enhancing patient safety and the quality of their care, and meeting the expectations of our stakeholders.
See also:	• World Health Organization. Global patient safety action plan 2021–2030: towards eliminating avoidable harm in health care. Geneva: World Health Organization. 2021. https://www.who.int/teams/integrated-health-services/patient-safety/policy/global-patient-safety-action-plan. • Coleman, B.C., Rubinstein, S.M., Salsbury, S.A. et al. The World Federation of Chiropractic Global Patient Safety Task Force: a call to action. Chiropr Man Therap 32, 15 (2024). https://doi.org/10.1186/s12998-024-00536-1

Introduction to Principle B:

It is essential to ensure that patients are kept safe when visiting any healthcare setting and seeking chiropractic care. Robust systems of safety in practice help keep them safe. These will promote safety, in the interest of preventing harm before harm

occurs. Prevention requires chiropractors to recognise safety incidents and to be clear that transparent reporting enables their own learning, and the learning of others, so action can be taken to reduce future risks to patients. Chiropractors need to be prepared to respond to emergencies in practice. They have a duty to act where they have concerns for the safety of any patient.

The accessibility of healthcare matters to patients. Chiropractors need to understand and recognise barriers to accessing healthcare, and how reasonable measures to address these may be taken in practice.

Assuring the quality of care provided is central to the protection of patients. This requires chiropractors to continually look for improvements to the quality of care provided to patients.

What has changed?	The introduction to Principle B sets out how it represents core shared values: **Safety And Quality.**

B1	protect patients by promoting and maintaining a culture of safety, seeking to prevent harm before it occurs.	
Code 2016:	*New standard*	
What has changed?	This new broad Standard puts the need to actively prevent harms to patients first and foremost in all aspects of practice. This will apply to clinicians treating patients as well as to registrant practice owners.	
Why has this change been made?	This brings the Code of Professional Practice in line the expectations of our stakeholders, with our new Education Standards, and with the standards of other regulators.	

B2	act promptly and appropriately when you have concerns about the safety of a patient, and record what you did.	
Code 2016:	**A3**	*take appropriate action if you have concerns about the safety of a patient.*
What has changed?	We have added the requirement for action to be taken 'promptly' to protect patients. We have also added the requirement to record steps taken.	
Why has this change been made?	We have made these minor amendments to signal the importance to act within an appropriate timeframe and highlight the need to keep adequate records of your actions.	

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.	
Code 2016:	**A6**	*treat patients in a hygienic and safe environment.*
	C9	*ensure all equipment used in your practice is safe and meets all relevant regulatory standards*
What has changed?	We have imported Standards A6 and C9 from the Code (2016) and combined them within new Principle B. We have broadened 'treat patients in...' to 'practise in..' We have specified an additional active requirement to 'identify and control risks'. We have broadened 'regulatory standards' to 'safety standards'. Examples are added to the glossary. We have also added a new requirement to have plans in place in case of emergency.	

Why has this change been made?	The amendments strengthen your governance requirements, to actively engage in risk management. They also broaden the responsibility to consider the safety of employees, colleagues and carers, in addition to patients. 'Safety standards' reflects the fact that not all applicable standards around the safety of equipment and the clinic environment are regulations. The new requirement to plan for the event of an emergency sets out the duty for practise governance to protect patients. This would include medical emergencies and providing first aid. The amendments bring the requirements in line with the standards of other health regulators.

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.
Code 2016:	*New standard*
What has changed?	We have introduced new requirements for your proficiency in relation to the principles of safety incident (and 'near miss') recognition and reporting. You need to be able to recognise and understand the importance of engaging with suitable reporting systems that permit the wider profession, as well as yourself, to learn from an incident.
Why has this change been made?	Stakeholders felt that engagement with safety systems was an important part of assuring wider patient safety and a key omission in the existing Code. Research conducted by the GCC (Registrant Survey, 2020) identified that there was variation in engagement with safety incident reporting systems in practice. The new standard sets out the knowledge that is required around recognising and reporting safety incidents. It recognises that the means of reporting incidents may vary, depending upon the practice setting, although a profession-wide safety system does exist. The addition of the new standard brings the Code in line with the Education Standards and with the requirements of other regulators.
See Also:	• GCC Registrant Survey 2020 - https://www.gcc-uk.org/assets/publications/GCC_Registrant_Survey_2020_-_main_report_final.pdf • Chiropractic Patient Incident Reporting and Learning System (CPiRLS) – https://cpirls.org/

B5	recognise the importance of promoting accessible healthcare for all patients, and recognise how this can be supported in your practice.
Code 2016:	*New standard*
What has changed?	We have added a new requirement for your knowledge around the accessibility of healthcare and how this may be supported in your practice. This would include the need to identify barriers and take *reasonable* measures to address these, so that all patients have equitable access to healthcare via your practice (see glossary for examples).
Why has this change been made?	Access to healthcare is a key factor in health outcomes for people. The new Education Standards address this, but the current Code does not. The proposed amendments update the Code in line with the Education Standards, best practice developments in healthcare, and the standards of other regulators.

B6	collect, evaluate and use feedback and data about the quality of care of patients to continuously improve your practice.
Code 2016:	*New standard*
What has changed?	We have introduced new requirements for governance in relation to the quality of care of patients. These require you to employ systematic approaches to monitoring, evaluating and seeking to enhance quality. It is recognised that appropriate quality management processes may differ, depending upon your practice setting.
Why has this change been made?	Our stakeholders told us that quality management was essential to good healthcare practice that puts patients at the centre of care. This was identified as a key omission in the existing Code. Research conducted by the GCC (Registrant Survey, 2020) identified that there was variation in the use of appropriate quality measures in practice. The addition of this new Standard updates the Code in line with gaps identified by stakeholders, with our Education Standards, and with the robust expectations of other regulators around the principles of quality management.
See also:	• GCC Registrant Survey 2020 - https://www.gcc-uk.org/assets/publications/GCC_Registrant_Survey_2020_-_main_report_final.pdf

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

Code 2016:	*Principle B:* *Act with honesty and integrity and maintain the highest standards of professional and personal conduct*
What has changed?	Current Principle B has now become Principle C, but is otherwise unchanged.

Introduction to Principle C:

Patients must be able to trust chiropractors. A chiropractor justifies the trust of patients and the public, both in themselves and in the profession, by upholding high standards of conduct at all times. Trust is earned by acting transparently and by demonstrating honesty, integrity and candour.

A chiropractor is expected to treat everyone fairly, promoting equality, diversity and inclusion, and to take an active role in tackling inequality and discrimination.

When sharing information, chiropractors are expected to uphold the reputation of the profession by being transparent and accountable. This applies when telling people about their services (advertising and any other promotional activities) and when sharing (or resharing) health information, by any medium. Information needs to be accessible (able to be read or received, and understood, by its intended audience) and must not exploit peoples' vulnerability or lack of health knowledge.

Professionalism also extends to managing one's own health and wellbeing, and to how personal views are expressed in interactions with patients and others. It includes the wider responsibilities of chiropractors as regulated healthcare professionals, including the duty to take action when they witness unprofessional behaviour by others.

What has changed?	The introduction to Principle C sets out how it represents core shared values: **Honesty, Integrity and Transparency; Professionalism.**

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.
Code 2016:	**B1**	*protect patients and colleagues from harm if your health, conduct or performance, or that of a regulated healthcare professional, puts patients at risk.*
What has changed?	A new clause is added that addresses taking care of your own health and wellbeing. The duty to protect from harm has been widened from 'patients' to 'others'.	

Why has this change been made?	The amendment recognises the increased awareness of health, wellbeing and mental health issues among healthcare professionals. It raises awareness and places emphasis on managing issues more widely, beyond situations where others are at risk of harm. Widening the duty from 'patients' to 'others', captures, for example, family or carers of patients. This updates the Code in line with the standards of other regulators.

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.
Code 2016:	*New standard*
What has changed?	This new Standard sets out your responsibility to evaluate your own fitness to practise, and to act promptly should this fall short, for any reason.
Why has this change been made?	By adding this new standard, we are being clear of your responsibility as an autonomous healthcare professional, and that you are expected to take action if you doubt your own fitness to practise. This is related to C1, however whereas C1 is about acting where others are placed at risk, C2 is about acting on the basis that your fitness to practise may be impaired.

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.	
Code 2016:	**B2**	*ensure you, and any chiropractor who works with you on a contractual basis, are properly qualified, registered and insured.*
What has changed?	We have added the specification that insurance and indemnity cover must include your full scope of practice. We have added the requirement for you to be clear with the patient that you are registered with the General Chiropractic Council. We have changed the duty relating to '..who works with you on a contractual basis..', to '..you employ, manage or lead..'. Where you employ, manage or lead anyone who holds a chiropractic qualification, there is a new requirement to be transparent with the patient about their regulated status.	

Why has this change been made?	While having appropriate insurance and indemnity for 'the day to day practise of chiropractic' is a requirement of registration, there is no requirement currently for this to extend to any additional practice approaches that you may use. The amended standard captures this requirement. The language in the Code (2016) is inaccurate, as nobody can be a 'chiropractor' unless they are properly qualified and registered. Some stakeholders raised concerns regarding public protection where an individual with a chiropractic qualification, but who is not registered, is contracted to work alongside other chiropractors under a different title. The amendment ensures that patients are made fully aware of whether they have the protection, or not, afforded when their clinician is a regulated health professional. The responsibility for this sits with you as an employer, manager or leader in the workplace.

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.	
Code 2016:	**B3**	*ensure your advertising is legal, decent, honest and truthful as defined by the Advertising Standards Authority (ASA) and conforms to their current guidance, such as the CAP Code.*
	G2	*maintain your knowledge to ensure it is up to date and accurate in terms of the law, regulations relevant to your work and GCC guidance.*
	H2	*only disclose personal information without patient consent if required to do so by law.*
	H7	*give patients access to their personal health records as required by law.*
What has changed?	The amendment from 'maintain' to 'take responsibility' emphasises that you must actively keep yourself up to date with key frameworks that govern your work. We have also added a requirement that you keep up to date with, and follow, Codes of Practice (as relevant) from other regulators.	
Why has this change been made?	These amendments clarify your professional responsibility to make sure that you know of, and apply key legislation, GCC guidance, Codes of Practice from other relevant regulators etc. For example, this will include, but is not limited to, the ASA/CAP, IRMER, ICO, all GCC guidance, all relevant statutory frameworks and guidance etc. This is in line with the expectations of other regulators. It is not expected that you will know or follow the Codes of Practice of other Healthcare regulators.	

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.	
Code 2016:	**B3**	*ensure your advertising is legal, decent, honest and truthful as defined by the Advertising Standards Authority (ASA) and conforms to their current guidance, such as the CAP Code.*

What has changed?	The focus has been changed from 'advertising' and the ASA's requirements, to more widely 'telling people about your services', and now specifies requirements for any such information that you provide to people. Reference to the ASA and the requirement to conform to the CAP Code has been removed (it is captured by C4).
Why has this change been made?	The focus on the current Code is on meeting requirements of the ASA, that is only with respect to advertising. The amendments to the standard reframe the principles in the context of patients and what they need from information. They also widen the scope to capture all of your promotional activities (e.g. patient reviews and testimonials, giving talks, blogs, articles etc). These are not all covered by the ASA and the CAP Code. C4 covers the requirement to comply with the ASA's CAP Code.
See also:	• Standard 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.

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.
Code 2016:	*New standard*
What has changed?	This standard introduces new requirements of you to assure the quality of any health information that you share. It is particularly focussed on online sharing of information, but will also apply when you publish in other media.
Why has this change been made?	Our stakeholders told us the current Code is outdated and does not fully address issues that can arise with the use of social media by healthcare professionals. The content of health information shared is a concern for all health professionals, due to the position of trust that they hold. The Academy of Medical Royal Colleges 'Assuring the credibility of health information sources on social media platforms' (2023) sets out the key principles to be followed (and is consistent with the NHS Standard for creating health content (updated 2024)). This new standard is in line with those principles, addressing the concerns of stakeholders, and bringing the Code up to date with wider developments in healthcare.
See also:	• Assuring the credibility of health information sources on social media platforms. Academy of Medical Royal Colleges - https://www.aomrc.org.uk/wp-content/uploads/2023/06/Credibility_health_information_social_media_310523.pdf • NHS Standard for creating health content, NHS Digital service manual (updated 2024) - https://service-manual.nhs.uk/content/standard-for-creating-health-content

C7	ensure your behaviour is professional at all times, upholding and protecting the reputation of the profession and justifying public trust.	
Code 2016:	**B5**	*ensure your behaviour is professional at all times, including outside the workplace, thus upholding and protecting the reputation of, and confidence in, the profession and justifying patient trust.*

What has changed?	'patient trust' has been widened, to 'public trust'. 'including outside the workplace' has been removed.
Why has this change been made?	'outside the workplace' is captured within 'at all times'. The amendments recognises the wider breadth of potential issues of trust of individuals and of the profession, beyond being trusted by patients. They also signal that professionalism, trustworthiness, honesty and integrity are important to uphold *at all times.*

C8	respect confidential information about the patient and preserve their dignity at all times, including online, during remote consultations, and when referring to them anonymously.
Code 2016:	**B4** *strictly maintain patient confidentiality when communicating publicly or privately, including in any form of social media or when speaking to or writing in the media.*
What has changed?	There is a new requirement to preserve patient dignity. 'Maintain patient confidentiality' has been amended to 'respect confidential information'. 'social media or when speaking to or writing in the media' has been widened to 'at all times'. 'including online, during remote consultations, and when referring to patients anonymously' has been added to signal that you need to be particularly careful in these situations.
Why has this change been made?	Our stakeholders told us of concerns about the confidentiality of conversations where these take place outside the traditional clinic setting, e.g. during remote consultations. The amendments recognise the developments in the use of remote healthcare consultations since the Code (2016) was published. Stakeholders also felt (and lessons have been learned from issues arising in other professions), that there is a need to emphasise the requirement to uphold the dignity of patients, for example when you publish details about them, or images, even where confidentiality is maintained and their consent gained. This is a right of the patient and also upholds the positive perception of the profession by the public.

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.
Code 2016:	*New standard*
What has changed?	We have introduced this new, broad Standard addressing business probity, conflicts of interest and inducements.

Why has this change been made?	Honesty, integrity and transparency was a core shared value between patients and registrants, that is addressed by this new standard. All stakeholder groups, including patients, told us that a key concern was that all care decisions should always be made in the best interests of patients and not influenced by any other factors. The current Code does not address wider business/financial probity, including around inducements of any form. This new standard has been added to be more explicit about the requirements for openness and integrity that underpin the trust of patients. The duty applies widely, to patients under your own direct care, or under the care of others. The amendment captures the wider requirement for financial probity in your business, and would include, for example, private medical insurers, employers etc, as well as transactions involving patients. The new standard makes it clear that patient care must not be in any way influenced by any interest that you have. It also sets out expectations of you with respect to inducements, that could take any form. The amendment brings the Code in line with the standards of other regulators, is consistent with the Joint regulatory statement on conflicts of interest, and meets the expectations of patients.
See also:	• Joint Regulatory Statement: Conflicts of Interest - https://www.gcc-uk.org/assets/publications/Conflicts_of_Interest_Joint_Statement_ENGLISH__WELSH_1.pdf

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.	
Code 2016:	**B6**	*avoid placing any undue financial pressure on a patient to commit to any long term treatment that is not justified.*
What has changed?	We have expanded B6, providing additional detail of our expectations around financial payment plans. In particular there is an explicit statement that when you determine a clinical plan of care, this must not be influenced by any financial payment plan. The content of the existing Standard has been re-phrased to be clear that any form of pressure placed on a patient regarding committing financially to long term treatment, is unacceptable.	
Why has this change been made?	Our stakeholders told us of concerns regarding the potential for care plans and recommendations to patients to be linked to financial payment plans. This is supported by the evaluation of FtP information that we carried out. We further discussed this with our registrants and listened to what you told us about how you offer and implement financial payment plans in practice, recognising that they may have benefits for some patients. The amendments to this standard set out our expectations for how payment plans are offered, and clearly define what would be considered unacceptable practice (this would include, for example, offering preferential or faster access to care for patients if they sign up to a payment plan).	

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.	
Code 2016:	**B7**	*fulfil the duty of candour by being open and honest with every patient. You must inform the patient if something goes wrong with their care which causes, or has the potential to cause, harm or distress. You must offer an apology, a suitable remedy or support, along with an explanation as to what has happened.*
What has changed?	Minor linguistic amendments have been made. There is also clarification that the explanation following something going wrong with care needs to include an explanation of actions to remedy the issue and also to prevent someone else from being harmed in the future.	
Why has this change been made?	The amendment to this standard clarifies the expectation regarding your explanations to a patient. This better reflects the GCCs Candour guidance, that provides further detail of the expectations, as well as the Regulators Joint Statement on Candour (2014)	
See also:	• Joint Regulatory Statement: Duty of Candour - https://www.gcc-uk.org/assets/publications/Joint_statement_on_the_professional_duty_of_candour.pdf	

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.
Code 2016:	*New standard*
What has changed?	The new Standard specifies your professional duty to consider your personal views and how these may impact others as well as an active duty to prevent these from being enacted. This extends beyond patients, to capture all of your professional relationships.
Why has this change been made?	Our stakeholders told us that EDI could be strengthened and that professionals should act as role models for others in upholding the principles. The enhanced inclusion of EDI considerations addresses developments in healthcare, improving care of patients and keeping the standards up to date and in line with those of other regulators.

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.
Code 2016:	*New standard*
What has changed?	The new Standard specifies that you have an active requirement to prevent poor practice by others, with respect to unfair or discriminatory behaviour. This extends more widely, beyond interactions with patients.

Why has this change been made?	Our stakeholders told us that EDI could be strengthened. Wider developments in the expectations of healthcare professionals, since the publication of the current Code, are that it is not sufficient to be only concerned with your own behaviour and practice. There is an active requirement for you to prevent poor practice by others, that is not included in the Code (2016). By taking action and raising concerns you prevent permitting unfair or discriminatory practices to occur, as a passive bystander. This strengthens the requirements around EDI considerations, in line with developments in healthcare more widely, keeping the standards up to date and in line with those of other regulators.

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.	
Code 2016:	**B8**	*justify and record your reasons for either refusing care or discontinuing care for a patient. You must explain, in a fair and unbiased manner, how they might find out about other healthcare professionals who may be able to offer care.*
What has changed?	Amendments clarify that any justification for refusing or discontinuing care of a patient must be reasonable. There is an additional requirement to record your justification.	
Why has this change been made?	The amendments better reflect the fact that you may refuse or discontinue care, but must have reasonable justification for doing so and this must be recorded.	

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).	
Code 2016:	**B9**	*follow established procedures for informing the GCC if you are subject to criminal proceedings or a regulatory finding has been made against you anywhere in the world. You must cooperate with the GCC when asked for information.*

What has changed?	Standard B9 (2016) has been expanded and split into 2 separate Standards (C15 and C16). There is a new requirement for relevant notifications to the GCC to be made 'promptly'. We have changed the threshold for informing the GCC from 'subject to criminal proceedings' (which would include arrest) to informing the GCC when you are 'charged with a criminal offence'. The threshold relating to notifications regarding 'regulatory findings' has been changed, to when there is any 'regulatory investigation' about you. A new wider requirement is added for you to notify the GCC of any actions taken as a result of concerns about your professional conduct or competence. This extends beyond criminal or regulatory investigations.
Why has this change been made?	Amendments to this standard provide clarification about when you need to notify the GCC of criminal or regulatory issues. The standard is also strengthened to include declaration of potential fitness to practice issues that may not have been reported to a regulatory body, for example, during or following an investigation into your performance or conduct within any health setting that you may work. These amendments strengthen the professional duty to protect patients and the public and brings the Code in line with the standards of other regulators.

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.	
Code 2016:	**B9**	*follow established procedures for informing the GCC if you are subject to criminal proceedings or a regulatory finding has been made against you anywhere in the world.* ***You must cooperate with the GCC when asked for information***
What has changed?	The final clause of B9 has been expanded in C16. We have added the requirement that your cooperation with investigations etc must be 'prompt' and 'full'. There is also now a wider requirement of you to cooperate with any 'formal investigation, inquiry, or complaints procedure into your own professional conduct or performance, that of others or the care of a patient'.	
Why has this change been made?	These amendments set out a wider duty to cooperate in formal procedures. These might, for example, include patient safety or harm issues, health service inquiries, investigations of malpractice by others etc. This is in recognition of the different roles and settings within which chiropractors do work, and the need for the Code to address all of these. The amendments strengthen your professional duty to protect patients and the public and bring the Code in line with the standards of other regulators.	

Principle D
You must provide a good standard of clinical care and professional practice

Code 2016:	*Principle C:* *Provide a good standard of clinical care and practice*
What has changed?	'clinical care and practice' has been amended to 'clinical care and professional practice'
Why has this change been made?	This change broadens Principle D to include other aspects of professional practice (e.g. engaging with research in practice), that might extend beyond the clinical aspects of your practice.

Introduction to Principle D:

A chiropractor is expected to provide good quality care that is patient-centred, safe and effective, and that is consistent with the current standards for good healthcare practice. This is supported by the use of critical thinking to underpin clinical approaches and integrating the best quality of evidence that is available at the time throughout the care of patients. This means chiropractors are expected to offer plans of care that follow the recommendations of authoritative clinical guidelines, within their own individual scope of practice. They need to have sound justification for their clinical recommendations and decisions about the care of patients and keep these under regular review.

When a chiropractor engages with developments in professional practice, such as new technologies and ways of working, they must do so safely and effectively to ensure benefit to the care of patients.

Chiropractors, given that they are well-placed through their interactions with patients and as health and care professionals, are expected to engage in interventions that support prevention and health promotion for the benefit of individuals and the population.

What has changed?	The introduction to Principle D sets out how it represents core shared values: **Patient-Centred Care; Safety and Quality.**

Clinical assessment and diagnosis or rationale for care

D1	take and record a thorough case history for the patient.	
Code 2016:	**C1**	*obtain and document the case history of each patient, using suitable methods to draw out the necessary information.*
What has changed?	We have added the requirement for the case history to be 'thorough'. We have removed the clause 'using suitable methods to draw out the necessary information.'	
Why has this change been made?	There was no specification of any required proficiency level that the case history must be at. The amendment strengthens this as the new required level is 'thorough'. 'using suitable methods' is pre-requisite to being able to 'take and record a thorough case history'.	

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.
Code 2016:	*New standard*
What has changed?	We have specified a new requirement for you to find out what your patient's goals of care are, at the outset of their care. We have also introduced a requirement to establish, from the outset, what the planned health outcomes of the care are, and how progress towards these will be measured. You must use recognised measures of health outcomes.
Why has this change been made?	Patient-centred care is one of the core shared values underpinning the Code review. Our stakeholders, including patients, told us of concerns around non-individualised care planning that does not address the patient's needs or provide valid means of monitoring their progress and response to care. This new standard is about finding out what matters most to the patient at the start of their care with you and what they want to achieve from it. It is also about specifying what outcomes for their health you expect and plan to realise through your care. These should be measurable through PROMs or physical function/performance measures that are recognised. (Some examples of suitable measures might include condition-specific or generic measures of pain, disability, physical function, health-related quality of life (e.g. SF-36) Patient's global impression of change (PGIC), or individualised outcomes identified by the patient themselves as important e.g. MYMOP (Measure yourself medical outcomes profile)) The new standard sets out the requirement to gather meaningful information from the outset of care, that will inform the rationale for person-centred care, its delivery and review. This is recognised good practice, benefits patients and is consistent with the requirements of other regulators.

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.	
Code 2016:	**C2**	*when carrying out a physical examination of a patient use diagnostic methods and tools that give due regard to patient health and dignity. You must document the results of the examination in the patient's records and fully explain these to the patient.*
What has changed?	We have amended C2 (2016) to specify the need to use those physical examination methods that are supported by the best evidence that is available at the time. Giving regard to patient health and dignity has been removed as this is covered in A3, and A4, respectively.	
Why has this change been made?	Our stakeholders told us that all aspects of care should informed by the best available evidence. Patients told us that they expected that chiropractors would draw upon the available evidence, in the same way as their GP. The existing standard makes no requirement for examination methods to be appropriate or evidence-based. 'Best available evidence' does not mean that examination methods with a low evidence level may not be used, recognising that there are limitations in evidence availability for in-clinic physical assessment methods, but does mean that where there are techniques that are better evidenced, you must prioritise those and give them greater weight in informing your clinical assessment and subsequent diagnosis. The amended standard applies to all instances where physical examinations are conducted. This amendment meets the expectations of stakeholders and brings the Code in line with the new Education standards and with the expectations of other regulators that care will be evidence-based.	

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.	
Code 2016:	**C8**	*ensure that investigations, if undertaken, are in the patient's best interests and minimise risk to the patient. All investigations must be consented to by the patient. You must record the rationale for, and outcomes of, all investigations. You must adhere to all regulatory standards applicable to an investigation which you perform.*

What has changed?	A minor amendment clarifies that imaging is included, along with other diagnostic investigations. There is an additional requirement to base decisions around carrying out investigations (either undertaking these yourself, or arranging them) on both clinical reasoning and authoritative evidence-based guidelines. The detail around recording the rationale and outcomes of investigations has been removed.
Why has this change been made?	Stakeholders told us that the relationship between the Code and the GCC Guidance on Diagnostic Imaging needed to be strengthened. The additional detail around the basis for investigations links to the Guidance. The detail around recording the rationale and outcomes of investigations has been removed, to reduce duplication with GCC Registrant Guidance on Diagnostic Imaging.
See also:	• The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2018 - https://www.legislation.gov.uk/uksi/2018/121/contents/made

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.
Code 2016:	**C3** *use the results of your clinical assessment of the patient to arrive at a working diagnosis or rationale for care which you must document. You must keep the patient fully informed.*
What has changed?	We have added a new requirement to keep the working diagnosis and rationale for care under review. We have also expanded the requirement to keep the patient informed, to include indicating diagnostic uncertainty
Why has this change been made?	Patient-centred care was a core shared value underpinning the reviewed Code. The amendments emphasise the need to keep reviewing the basis for your care of the patient, and to provide them with all of the information that they need to engage with decisions about their care and to give their valid consent.

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.
Code 2016:	**C4** *develop, apply and document a plan of care in full agreement with the patient. You must check the effectiveness of the care and keep the plan of care under review. A more formal reassessment of the effectiveness of the plan of care must be undertaken at intervals that suit the patient and their needs. All subsequent modifications to the plan of care must be discussed and agreed with the patient and properly documented.*

What has changed?	C4 (2016) has been expanded upon and broken down into four standards D6, D8, D9 and D10. We have included greater detail in D6 (see also D7 and D8) specifying our expectations for how you develop a plan of care. There is a requirement for you to include in your proposals to the patient those approaches that are supported by the best available evidence. There is also a requirement to be clear with the patient where options are not well-supported by evidence.
Why has this change been made?	Patient-centred care, and honesty, integrity and transparency are core values shared between patients and registrants. Our stakeholders identified the need for all aspects of care to be informed by the best available evidence, and the importance of shared decision-making and consent. This standard is about the care options that you put forward to the patient, making sure that you do include those with the best evidence of effectiveness (within your limits of knowledge, skills and competence, as specified in I5). In making these amendments, we recognise that it would be unreasonable to only permit care approaches for conditions with an acceptable evidence-base, as this may impede patient choice and further research innovation. However, patients must be able to make informed choices about their care, understanding uncertainty in likely effectiveness, for their consent to be valid. These options will be taken into account subsequently as you apply evidence-based practice (set out in D8) to decide with the patient what their plan of care will be. These amendments reflect the core shared values of patient-centred care and honesty, integrity and transparency. They also strengthen and update the Code with respect to evidence-based practice, shared decision-making and consent, in line with other regulators and the expectations of our stakeholders.

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).	
Code 2016:	**E1**	*share with the patient accurate, relevant and clear information to enable the patient to make informed decisions about their health needs and relevant care options. You must also take into consideration a patient's capacity to understand.*
	F1	*explore care options, risks and benefits with patients, encouraging them to ask questions. You must answer fully and honestly, bearing in mind patients are unlikely to possess clinical knowledge.*
What has changed?	We have combined and amended E1 (2016) and F1 (2016) to clarify the requirement for you to inform the patient of the risks, benefits and alternatives to your proposed care and also include in this the option for 'no care'.	

Why has this change been made?	Our stakeholders told us that shared decision-making and consent needed to be strengthened in the Code. The amendments to this standard specify essential elements that underpin shared decision-making and the process of obtaining good quality consent to care. This addresses what stakeholders told us and updates the Code in line with other regulators.

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.	
Code 2016:	**C4**	*develop, apply and document a plan of care in full agreement with the patient. You must check the effectiveness of the care and keep the plan of care under review. A more formal reassessment of the effectiveness of the plan of care must be undertaken at intervals that suit the patient and their needs. All subsequent modifications to the plan of care must be discussed and agreed with the patient and properly documented.*
What has changed?	D8 sets out the requirement for you to apply evidence-based practice to develop and implement a plan of care for the patient. There is a new requirement for you to include in your plan of care how and when you will monitor progress towards the planned health outcomes that were established in D2, making sure that this is explained to the patient and recorded with the plan of care. We have added a clear statement that it will not be acceptable to propose a plan of care that is not justified on the basis of your clinical assessment of the patient (D1, D2, D3 and D4) and relevant subsequent reassessments (D9). We have added clarification that the valid consent of the patient must be obtained before the plan of care is implemented.	
Why has this change been made?	Patient-centred care is a core shared value between patients and registrants. Our stakeholders, including patients, told us of concerns about the potential for unnecessarily long care plans to be implemented without justification, and felt that reviews of care may not be meaningful. Our evaluation of Fitness to Practice data also indicated that this can be a problem area of practice. This standard places the patient at the centre of their care. The amendments provide greater detail about what you are expected to include and explain to the patient when developing your plan of care for them. It addresses planning for monitoring the progress of your patient and evaluating their care plan. This standard strengthens the requirements around your development of, and justification for the care plan. The updates meet the expectations of stakeholders, and address FtP issues that have arisen by providing clarity on what is, or is not acceptable.	

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.
Code 2016:	**C4** *develop, apply and document a plan of care in full agreement with the patient. You must check the effectiveness of the care and keep the plan of care under review. A more formal reassessment of the effectiveness of the plan of care must be undertaken at intervals that suit the patient and their needs. All subsequent modifications to the plan of care must be discussed and agreed with the patient and properly documented.*
What has changed?	We have included greater detail in D9 specifying our expectations for monitoring and reviewing the patient's progress and plan of care. We have clarified that monitoring of progress must be continuous throughout care, the need to record this, and to evaluate and adapt the plan of care as necessary. We have added an additional requirement that your formal reassessments must be at intervals that have been pre-agreed with the patient (following on from D8). We have included an additional requirement that in evaluating the effectiveness of care, you use recognised outcome measures (following on from D2).
Why has this change been made?	Patient-centred care is a core shared value between patients and registrants. Our stakeholders, including patients, told us of concerns about the potential for unnecessarily long care plans to be implemented without justification, and felt that reviews of care may not be meaningful. Fitness to practice data also indicated that this can be a problem area of practice. This standard strengthens the requirement for your ongoing care of the patient to be monitored and determined through meaningful reassessments that are specific to each patient. It relates back to D2 where the relevant recognised outcome measures will have been determined. The amendments address concerns raised by stakeholders, and FtP issues that have arisen.

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.
Code 2016:	**C4** *develop, apply and document a plan of care in full agreement with the patient. You must check the effectiveness of the care and keep the plan of care under review. A more formal reassessment of the effectiveness of the plan of care must be undertaken at intervals that suit the patient and their needs. All subsequent modifications to the plan of care must be discussed and agreed with the patient and properly documented.*

	C6	*cease care, or aspects of care, if this is requested by the patient or if, in your professional judgement, the care will not be effective, or if, on review, it is in the patient's best interest to stop. You must refer the patient to another healthcare professional where it is in their best interests.*
What has changed?	We have clarified that your discussions with the patient around continuing or modifying their care plan must be focussed around the planned health outcomes (that were identified in D2). We have amended the requirement to 'agree' modifications with the patient, to the requirement that you have their 'valid consent'. We have removed the specific reference to ceasing care.	
Why has this change been made?	Patient-centred care is a core shared value between patients and registrants. Our stakeholders also told us that shared decision-making and consent need to be strengthened in the Code. The amendments signal the need to fully involve patients in their care, sharing necessary information that is specific to them, in order for their consent to be valid. Ceasing care is considered to be included within modifications to care plans. The amendments meet the expectations of stakeholders and update the Code in line with good healthcare practice and the requirements of other regulators.	

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.	
Code 2016:	**C5**	*select and apply appropriate evidence-based care which meets the preferences of the patient at that time.*
What has changed?	We have amended 'evidence-based care', to 'evidence-based practice'. We have added the specification for you to select and implement care that is safe. We have specified that care could include (although is not limited to) manual techniques, rehabilitative interventions and psychologically informed approaches, and education and advice. We have added a requirement for you to encourage and support patients to self-manage their health, and, in doing so, for you to make use of signposting to resources.	

Why has this change been made?	Patient-centred care is a core shared value between patients and registrants. Supporting self-management and signposting are important parts of this. Our stakeholders also told us that patient centred care should be strengthened. They also felt that there was a gap in the current Code, whereby it does not indicate what sort of care a chiropractor could typically provide. The amendment outlines a range of approaches that you use, as a chiropractor. This is consistent with the Education Standards (2023) and with Outcomes for Chiropractic Graduates (2022). Supporting self-management and signposting are consistent with the skills for health person-centred approaches framework (2017). The amendments address the gaps identified by stakeholders, strengthen patient-centred care within the Code and update it in line with wider developments in healthcare practice.
See also:	• GCC Education Standards (2023) - https://www.gcc-uk.org/education-and-registration/education-standards • RCC Outcomes for Chiropractic Graduates - https://rcc-uk.org/wp-content/uploads/2022/05/Outcomes-for-Chiropractic-Graduates_FCD_May-2022.pdf • Skills for Health - person centred approaches Framework - https://www.skillsforhealth.org.uk/wp-content/uploads/2021/01/Person-Centred-Approaches-Framework.pdf

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.	
Code 2016:	**C6**	*cease care, or aspects of care, if this is requested by the patient or if, in your professional judgement, the care will not be effective, or if, on review, it is in the patient's best interest to stop.* ***You must refer the patient to another healthcare professional where it is in their best interests.***
	C7	***follow appropriate referral procedures when making a referral or a patient has been referred to you; this must include keeping the healthcare professional making the referral informed. You must obtain consent from the patient to do this.***
What has changed?	We are merging content from C6 (2016) and C7 (2016) around referrals, into a single new Standard (D12).	
Why has this change been made?	Stakeholders told us that the standard of proficiency regarding keeping other healthcare professionals informed regarding referrals was not high enough as there is no level specified for a standard to which this should be done. There is clarification that referrals must be made, received and implemented at a level that is *effective*, as this underpins safe, proficient practice. The merging of C6 and C7 reduces duplication within the Code.	

D13	engage in evidence-based interventions that support prevention and health promotion, considering health inequalities, for the benefit of the patient and population health.
Code 2016:	*New standard*

What has changed?	We have introduced new requirements of you to engage in prevention and health promotion interventions. We have introduced a new requirement of you to take into consideration health inequalities.
Why has this change been made?	The need to engage in prevention and health promotion was identified by our stakeholders as a gap in the Code (2016). The new Education Standards already address this. This standard is about applying prevention and health promotion interventions that are supported by evidence. It means those approaches that are within your individual scope of practice, as a chiropractor, and might for example include providing information or signposting patients to further resources. Understanding around health inequalities underpins the ability to effectively promote health and prevent ill health across different socioeconomic groups. This new standard updates the Code in line with the expectations of our stakeholders, with the Education Standards, and with the newer requirements of other healthcare regulators, recognising developments in healthcare practice.

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.
Code 2016:	*New standard*
What has changed?	This standard sets out new requirements for how digital technologies are used in practice.
Why has this change been made?	Our stakeholders told us that the use of information, communication and digital technology was a key gap in the existing Code. This included with respect to advances in technology and developments in the settings for care delivery. Appropriate use can benefit patients, for example the use of electronic PROMs systems, signposting to electronic resources and virtual consultations. Future applications may include the use of Artificial Intelligence (that is included within 'new technology'). This new standard addresses the use of those technologies and also changes from traditional care delivery settings. This updates the Code to meet the gap identified by our stakeholders and brings it in line with both the Education Standards and the standards of other healthcare regulators.

D15	ensure that in promoting or conducting research or using research in practice, you do so ethically and effectively.
Code 2016:	*New standard*
What has changed?	This broad standard sets out new requirements for how you engage with research.

Why has this change been made?	This was identified as a gap by our stakeholders, particularly with respect to the varying roles that chiropractors may hold, and the need to uphold professional standards in both clinical and non-clinical roles (e.g. research and education). This broad new standard is intended to capture any situation where you are involved with research. This includes, for example, participating in practice-based research, how you represent the findings of research to others (including patients), as well as more formal research roles. The requirement will be proportionate to your level of research involvement. This updates the Code in line with the Education Standards, the standards of other regulators and the minimum research competency recommendations of the Council for Allied Health Professions Research (CAHPR) for beginner and established practitioners. This takes account of the view of stakeholders who felt that the Code is focussed on clinical practice but should also capture standards for chiropractors engaged research.
See also:	For details on recommended junior practitioner ("awareness" level) and established practitioner ("core" level) research competencies, to support evidence-based practice, see: • Council for Allied Health Professions in Research (CAHPR) Research Practitioner Framework (Harris et al, 2019) - https://cahpr.csp.org.uk/system/files/documents/2019-11/Shaping%20Better%20Practice%20Through%20Research%20A%20Practitioner%20Framework.pdf

Principle E
You must establish and maintain clear professional boundaries

Code 2016:	*Principle D:* *Establish and maintain a clear professional relationship with patients*
What has changed?	'Relationship with patients' has been amended to 'boundaries'.
Why has this change been made?	The amendment extends the breadth of the Principle beyond only applying to patients. It also shifts the focus from 'relationships' to 'boundaries', in line with wider thinking in healthcare.

Introduction to Principle E:

Healthcare professionals occupy a position of power and trust, with respect to patients and others. Patients, and those close to them, must be able to trust that those involved in their care will behave professionally towards them. Power imbalances between colleagues can also exist and must not affect professional conduct (this includes when training or supervising others).

Patients are protected when their chiropractor ensures that all of their conversations and interactions with the patient are confined within the limits set by proper boundaries for the professional relationship. This includes ensuring that patients, and others who accompany them, are treated respectfully and with dignity, that patients feel comfortable with interactions, and that their needs or preferences for chaperones or advocates are considered. This enables care to be provided in effective partnership with the patient.

What has changed?	The introduction to Principle E sets out how it represents core shared values: **Safety and Quality; Professionalism; Honesty, Integrity and Transparency.**

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.	
Code 2016:	**D1**	*not abuse the position of trust which you occupy as a professional. You must not cross sexual boundaries.*
What has changed?	We have added 'recognise the power imbalance that comes with being a healthcare professional' We have expanded 'position of trust' to 'position of power and trust'. We have broadened the standard from 'sexual boundaries' only, to all 'professional boundaries', and to include 'improper financial, emotional and personal relationships'.	

Why has this change been made?	Our stakeholders told us that a fuller breadth around improper influencing and relationships was needed, to better protect patients and the public. They identified that the focus should be on power imbalances and boundaries. Analysis of FtP data also supported this. The amendments signal that improper relationships are not confined to the crossing of sexual boundaries. The new knowledge-based requirement to recognise the role of power imbalances signals that this is an important part of the standard of proficiency of a chiropractor, that underpins the management of professional relationships. The amendments provide greater clarity for chiropractors around the expectations of them, addressing FtP issues that have arisen. This updates the Code in line with developments in thinking around boundaries and relationships across healthcare. This will be supported by development by the GCC of new 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.	
Code 2016:	**D2**	*be professional at all times and ensure you, and any staff you employ, treat all patients with equal respect and dignity.*
What has changed?	We have removed 'be professional at all times' (captured in C6). 'staff you employ' has been changed to 'any person you employ, manage or lead'. 'treat all patients' has been expanded to 'treat all patients, their carers or others accompanying them'.	
Why has this change been made?	These amendments clarify that your duty extends beyond staff that work for you on an employed basis. They also broaden the standard, extending it to also capture carers, chaperones, interpreters, advocates or family who may accompany the patient, who are not considered in the current Code.	

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.	
Code 2016:	**D3**	*explain the reason to the patient if there is a need for the patient to remove items of clothing for examination; if that needs to happen, you must offer the patient privacy to undress and the use of a gown.*
	E6	*always obtain a patient's consent if it becomes necessary for the purposes of examination and treatment during care, for you to adjust and/or remove items of the patient's clothing.*
What has changed?	Standards D3 (2016) and E6 (2016) have been combined. There are minor linguistic changes.	
Why has this change been made?	The change reduces duplication within the Code.	

<table>
<tr><td>E4</td><td>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.</td></tr>
<tr><td>Code 2016:</td><td>D4 consider the need, during the assessments and care, for another person to be present to act as chaperone; particularly if the assessment or care might be considered intimate or where the patient is a child or a vulnerable adult.</td></tr>
<tr><td>What has changed?</td><td>'consider the need for…' has been expanded to 'consider the need for (or advisability of)…..'

The use of advocates, as well as chaperones, has been added to this standard.

There is a new additional requirement to 'wherever possible, offer a chaperone....'

We have added an additional requirement for this to be applied 'where the patient requests..'.

There is an added requirement to record when a chaperone or advocate has been offered."</td></tr>
<tr><td>Why has this change been made?</td><td>Our stakeholders told us that the use of chaperones should be strengthened and that the use of advocates should also be included.

The amendments broaden the existing standard to include the wider use of chaperones and of advocates for patients, as necessary. The level of the requirement is strengthened around offering a chaperone, where possible, and also around recording this.

This brings the Code in line with the recommendations of our stakeholders, the expectations of the new Education Standards and with the standards of other healthcare regulators.</td></tr>
</table>

Principle F You must obtain appropriate, valid consent from patients	
Code 2016:	*Principle E:* *Obtain informed consent for all aspects of patient care*
What has changed?	"All aspects of patient care" has been removed.
Why has this change been made?	This broadens the requirement for consent to also include non-care-related situations, such as participation in research or education.

Introduction to Principle F:	
Patients have the right to determine what happens to them, and chiropractors have legal and ethical duties to obtain valid consent from the patient, or other valid authority, for clinical, and some non-clinical procedures. For consent to be valid, it must be voluntary, informed (based on accurate information including risks and benefits) and the individual giving consent must have the capacity to make the decision.	
What has changed?	The introduction to Principle F sets out how it represents core shared values: **Honesty, Integrity and Transparency; Patient-Centred Care; Safety and Quality; Professionalism.**

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.	
Code 2016:	**E1**	*share with the patient accurate, relevant and clear information to enable the patient to make informed decisions about their health needs and relevant care options. You must also take into consideration a patient's capacity to understand.*
What has changed?	There is a new requirement for information given to the patient to be in an accessible format. There is a strengthened requirement to actively check that the patient understands the information. "capacity" has been removed, as this more accurately refers to consent, and is captured in F2.	

Why has this change been made?	Patient-centred care is a core shared value between patients and chiropractors. Shared decision-making is an important part of person-centred approaches to care. Our stakeholders told us that this should be given greater emphasis than currently. This standard is about informing the patient, prior to them making decisions and consenting. To be 'informed' the patient needs to have been given the relevant information, this needs to be accessible to them and they also need to have understood this sufficiently. These amendments strengthen the requirements around person-centred approaches to care and shared-decision making, updating the Code in line with best practice developments in healthcare, with the recommendations of our stakeholders and with the professional standards of other regulators.
See also:	• Skills for Health - person centred approaches https://www.skillsforhealth.org.uk/resources/person-centred-approaches-2017/ • NICE Guidance – shared decision making: https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making

F2	give due regard to the capacity of the patient to give valid consent, considering that their capacity can change over time.	
Code 2016:	**E1**	*share with the patient accurate, relevant and clear information to enable the patient to make informed decisions about their health needs and relevant care options. You must also take into consideration a patient's capacity to understand.*
What has changed?	Capacity has been amended to focus more broadly on the capacity to consent, rather than the narrower capacity to understand.	
Why has this change been made?	This updates the Code, in line with the GCC Guidance on Consent (2022)	

F3	ensure the consent of the patient is voluntarily given, without pressure, or undue influence.	
Code 2016:	**E4**	*ensure the consent of a patient is voluntary and not under any form of pressure or undue influence.*
What has changed?	Minor linguistic change only	

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.	
Code 2016:	**E2**	*obtain and record consent from a patient prior to starting their care and for the plan of care.*
	E3	*check with the patient that they continue to give their consent to assessments and care.*
What has changed?	'consent from a patient' has been broadened to 'consent from a patient (or their valid authority)'. The requirement for when consent is needed has been expanded, from clinical care only, to also now include where the patient is involved in teaching, research, where a recording of them is made or where disclosing identifiable information about them.	
Why has this change been made?	There are gaps in the current Code whereby it does not address situations where a patient does not have capacity to consent; and the need to obtain consent for non-clinical care-related reasons. These updates more accurately reflect who may provide consent for a patient, capturing consent in situations where a patient may not have capacity e.g. somebody with an LPA. The amendments set out non care-related situations where consent must be obtained. The inclusion of consent for making recordings (audio or images) addresses developments in the use of media sharing and social media. The amendments address gaps in the Code and bring it up to date.	

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.	
Code 2016:	**E5**	*seek parental consent first if a child is to be seen without someone else being present, unless the child is legally competent to make their own decisions.*
What has changed?	The requirement has been broadened to include other patients who may be vulnerable, in addition to children. The consent of a 'valid authority' has been added.	
Why has this change been made?	These updates more accurately reflect who may provide consent for a patient, capturing consent in situations where a patient may not have capacity. The amendments also better reflect the fact that adult patients may also be vulnerable and that the same considerations apply around consent, as for a child.	

Principle G
You must communicate professionally, properly, and effectively

Code 2016:	*Principle F:* *Communicate properly and effectively with your patients, colleagues and other healthcare professionals*
What has changed?	We have added the requirement to communicate “professionally”. We have removed “with your patients, colleagues and other healthcare professionals”.
Why has this change been made?	The requirement to communicate ‘professionally’ captures all communications as part of professional practice. This might, for example also include with advocates, carers or family of patients, that were not included previously.

Introduction to Principle G:

The safety of patients, the quality of their care and the provision of patient-centred care require chiropractors to communicate well with patients, their advocates, carers and family, colleagues, and other healthcare professionals. Duties relating to communication also extend to the wider sharing of information by the chiropractor, as a healthcare professional, through all communication channels.

What has changed?	The introduction to Principle G sets out how it represents core shared values: **Honesty, Integrity and Transparency; Safety and Quality; Patient-Centred Care; Professionalism.**

G1	take reasonable steps to understand and meet the language and communication needs and preferences of the patient, while maintaining their privacy.
Code 2016:	**F4** *take account of patient communication needs and preferences.*
What has changed?	“Take account” has been changed to “take reasonable steps”. “Language needs” has been added, in addition to “communication needs”. There is an added requirement to maintain the patient's privacy during communication.
Why has this change been made?	Patient-centred care is a core shared value between patients and chiropractors. Good communication is essential to person-centred approaches. The standard is strengthened, signalling the expectation that modifications will be made, where possible, to facilitate effective communication with patients. This underpins the principle of person-centred care. Amendments also clarify the expectation that the patient's language needs and preferences are sufficiently addressed, in addition to other communication needs and preferences. 'Reasonable steps' is defined in the glossary. This updates the Code in line with our Education Standards and the standards of other healthcare regulators.

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.	
Code 2016:	**F1**	*explore care options, risks and benefits with patients, encouraging them to ask questions. You must answer fully and honestly, bearing in mind patients are unlikely to possess clinical knowledge.*
What has changed?	The amendment places the emphasis on how clinical information should be communicated, rather than on what should be communicated (this is captured in D7).	
Why has this change been made?	Patient-centred care is a core shared value between patients and chiropractors. Good communication and shared decision-making are essential to person-centred approaches. Stakeholders also told us that shared decision-making was under-represented in the current Code. The amendments recognise the impact that language and communication can have on patient outcomes. This updates the Code in line with what stakeholders told us, with our Education Standards and the standards of other healthcare regulators.	

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.	
Code 2016:	**F2**	*have visible and easy-to-understand information on patient fees, charging policies and systems for making a complaint. These policies must include the patient's right to change their mind about their care, and, their right to refer any unresolved complaints to the GCC.*
	F5	*listen to, be polite and considerate at all times with patients including regarding any complaint that a patient may have.*
What has changed?	There is an added requirement to respond quickly to any complaints that arise. There is an added requirement to consider making policies available in the Welsh language, if you practise in Wales. We have removed F5 (2016) as this is captured by A2.	
Why has this change been made?	The addition of a duty to respond promptly to complaints is in the interest of patients and may help to prevent the escalation of dissatisfaction into Fitness to Practise (FtP) complaints. The addition of considering making policies available in the Welsh language is in the interest of meeting patient communication preferences.	

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).	
Code 2016:	**E7**	*obtain and record the express consent (i.e. orally or in writing) from the patient regarding sharing information from their patient record. You must not disclose personal information to third parties unless the patient has given their prior consent for this to happen – see also H2.*
	F3	*involve other healthcare professionals in discussions on a patient's care, with the patient's consent, if this means a patient's health needs will be met more effectively.*
	H2	*only disclose personal information without patient consent if required to do so by law.*
What has changed?	The requirement to 'involve other healthcare professionals in discussions' has been amended to 'communicate effectively'. The patients 'care needs and goals' has been added to their 'health needs'. '(You must) obtain and record the express consent.....You must not disclose personal information ..' has been changed to 'You must only share information with the consent...' 'only disclose ...if required to do so by law.' has been changed to '..only share...another lawful basis to do so'	
Why has this change been made?	Principle G is about communication. The changes emphasise the expected standard of the quality of communication with other healthcare professionals (i.e. that communication must be effective), rather than only the requirement to involve them in discussions. E7 (2016) and H2 (2016) both deal with consent in relation to consent for the disclosure of information. They are merged to this standard to enhance compliance with legal requirements, to simplify articulation of the requirement and reduce duplication. This amendment updates the Code in line with our Education Standards.	

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.	
Code 2016:	**F6**	*provide information to patients about all individuals responsible for their care, distinguishing, if needed, between those responsible for delegated aspects and for their day-to-day care. This must include the arrangements for when you are not available.*
What has changed?	There are new specifications that the information that must be given to patients about those providing their care includes whether or not that person is a regulated health professional, and who the accountability for that care sits with.	
Why has this change been made?	The amendment has been made in the interest of providing better clarity to patients about the roles of others who you involve in their care. This is to ensure that patients fully understand the regulated status of those involved and whether you, or the other person, hold accountability, should something go wrong with that care.	

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.
Code 2016:	*New standard*
What has changed?	This new standard introduces requirements for the way in which you communicate and interact with patients and the wider public through digital media.
Why has this change been made?	Our stakeholders told us that the 2016 Code did not adequately cover issues related to the use of media sharing and social networking sites. Analysis of Fitness to Practise (FtP) cases also identified some instances of improper use of these. This standard is about the way that you use newer digital media in your communications with patients or the wider public (in contrast, C5 is about the content of any health information that is shared). The new standard addresses the concerns of our stakeholders and also FtP issues that have arisen, setting out what is expected of you, as a chiropractor, when using media sharing and social networking sites to provide information to, or to communicate with patients or the wider public.

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

Code 2016:	*Principle H is new*
What has changed?	We are introducing a new Principle focussed on working with others. It is comprised of a number of new standards, and also imports 2 amended existing standards - F3 (2016) and G6 (2016).
Why has this change been made?	Our stakeholders told us that collaborative care, interprofessional relationships and aspects of workplace culture are important elements of what good practice should look like, identifying that they were not sufficiently captured in the Code (2016). Some stakeholders raised concerns about the workplace culture that new graduates are sometimes exposed to (e.g. lack of support to adhere to the Code). The new principle will address requirements of the varied and widening range of environments within which chiropractors do work. This will ensure both effective direct care of patients and also effective wider service delivery, for the benefit of patients.

Introduction to Principle H:

To keep patients safe, and to ensure the quality of their care, it is essential that chiropractors work well with others, within the workplace, and externally and inter-professionally. This includes maintaining effective and respectful professional relationships to underpin collaboration in the care of patients. Where tasks or duties have been delegated to others to do on their behalf, the chiropractor will remain accountable.

Chiropractors need to be able to work effectively as part of a team (where this is required) to deliver and enhance the care of patients. This may include engaging with the design, delivery or enhancement of healthcare services more widely.

Leadership as a healthcare professional is more than the management or supervision of others, it is an attribute all chiropractors are able to demonstrate. Leadership will mean different things in different roles and there are many ways to show leadership.

Chiropractors are expected to promote a positive culture in the workplace, as well as fulfilling their duty to act upon the poor behaviour of others by following local resolution procedures within their workplace. They are also required to give professional support to others, where appropriate.

What has changed?	The introduction to Principle H sets out how it represents core shared values: **Safety and Quality; Patient-Centred Care, Professionalism.**

H1	collaborate appropriately and effectively with other health and care professionals, to enhance the integrated care of patients.
Code 2016:	**F3** *involve other healthcare professionals in discussions on a patient's care, with the patient's consent, if this means a patient's health needs will be met more effectively.*
What has changed?	There is a new requirement to collaborate effectively with other health and care professionals. There is specification that the integrated care of the patient must be enhanced.
Why has this change been made?	Professionalism is a core shared value between patients and chiropractors. Our stakeholders, including patients, told us that it was important for chiropractors to collaborate with other healthcare professionals and foster good interprofessional relationships. The current Code only included the requirement to involve others in discussions. The amendments strengthen the requirements for collaborative care. This applies both within the workplace and more widely. This updates the Code in line with the expectations of stakeholders, with the new Education Standards and with the standards of other healthcare regulators.

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.
Code 2016:	**G6** *not require anyone else to take on responsibilities for patient assessment and care where it would be beyond their level of knowledge, skills or experience.*
What has changed?	Requirements around delegation have been moved from the current Principle G (2016) (relating to your own knowledge, skills and competencies), into this new Principle H that includes workplace practices. The standard has been re-worded to include 'delegate'. There is a new requirement to delegate 'safely'. There is a new requirement of the chiropractor to ensure appropriate support and supervision of the person being delegated to.
Why has this change been made?	Safety and quality is a core shared value between patients and chiropractors. The delegation of care to others is a key area for the assurance of safety of patients. The amendments strengthen the requirements around delegation and clarify the responsibilities of the chiropractor when delegating to others. This updates the Code in line with our new Education Standards and with the standards of other healthcare regulators.

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.
Code 2016:	*New standard*
What has changed?	We have added new requirements addressing teamworking and professional interpersonal relationships. The standard also sets out the need for engagement with the healthcare service within which one works, as required according to the role of the chiropractor and the setting.
Why has this change been made?	Our stakeholders identified gaps in relation to team working and to interprofessional and multiprofessional relationships and working. The new Education Standards have already addressed these, as do the newer standards of other health regulators. This new standard recognises that chiropractors do work in a varied and widening range of environments and that the opportunity and requirements for team working and professional interpersonal relationships will vary accordingly. The changes accommodate all practice settings and the different roles within which chiropractors work. This will ensure both effective direct care of patients and also effective wider service delivery e.g. in larger chiropractic or multi-professional settings, for the benefit of patients. This brings the Code in line with the expectations of our stakeholders, the requirements of our Education Standards and the standards of other healthcare regulators.

Your professional responsibility towards colleagues

H4	demonstrate leadership appropriate to a healthcare professional and to your role.
Code 2016:	*New Standard*
What has changed?	There is a new requirement for the leadership role that every chiropractor has.
Why has this change been made?	Our stakeholders identified gaps in relation to leadership. The new Education Standards have already addressed this, as do the newer standards of other health regulators. This standard is not only about leadership during the management or supervision of others. It is an attribute all registrants should be able to demonstrate in their everyday practice, whatever their role. Some examples are: having the ability to persuade others to do their best to achieve a desired result; improving and innovating patient care through clinical leadership; decision-making in professional practice; self-development; advocating for patients. This amendment updates the Code in line with the recommendations of our stakeholders, our Education Standards and the standards of other healthcare regulators.
See also:	• NHS Leadership Framework from NHS Leadership academy - https://www.leadershipacademy.nhs.uk/wp-content/uploads/2014/11/Leadership-Framework.pdf

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.
Code 2016:	*New standard*
What has changed?	There are new requirements around workplace behaviours.
Why has this change been made?	Our stakeholders identified workplace culture as a gap in the existing Code. This has also been recognised as an issue in other healthcare disciplines, that impacts patient care and safety, and is addressed in the newer standards of other health regulators. This new Standard specifically addresses poor workplace behaviours (bullying, harassment and intimidation) towards others. The duty to take action discourages the passive bystander role, but acknowledges that there may be instances where hierarchies and circumstances within the workplace impact upon what a chiropractor may be reasonably expected to do. It is recognised that chiropractors work in a range of different workplace settings and roles, and that the appropriate procedures may vary accordingly.

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.
Code 2016:	*New standard*
What has changed?	There are new requirements around reporting concerns and responding to reports of concerns that colleagues are putting others at risk of harm.
Why has this change been made?	Safety and quality, and professionalism are core shared values between patients and chiropractors. Our stakeholders identified workplace culture as a gap in the existing Code. This is an area where issues in other healthcare professions have arisen, resulting in harm to patients, workplace colleagues and others. B2 captures the duty to protect others, where issues of your own, or others, health, conduct or performance, puts them at risk, while C12 outlines a duty to raise concerns about unfair or discriminatory behaviours. This new standard is more specifically about the duty to report or whistleblow, within the workplace and to follow this up appropriately. The use of putting '…others…' at risk of harm captures patient safety and welfare, but also that of their carers, anyone else accompanying them, and all workplace colleagues. These amendments acknowledge that chiropractors work in a range of different workplace settings and roles, and that the appropriate actions may vary accordingly. The amendments address the recommendations of our stakeholders and issues of patient protection and of poor workplace culture that have arisen in other healthcare disciplines due to inadequacy of reporting or failure for action to be taken when concerns have been raised.

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.
Code 2016:	*New standard*
What has changed?	There are new requirements around developing and supporting others in their professional learning. There is also a new requirement that, as a chiropractor, you do not get in the way of enabling others that you work with to meet our standards. This will particularly apply where you oversee more junior colleagues, and a power imbalance exists.
Why has this change been made?	Our stakeholders told us of issues whereby new graduates and associates do not always receive the support that they need in the workplace. This can include inadequate support and mentoring for transition into practice, as well as workloads, practice requirements and inducements whereby measures of their performance do not support them to meet the requirements of the Code. There is also recognition that placements in 'real world' practice settings are valuable for chiropractic students. It is likely that the requirements and opportunities for practice-based learning settings and for chiropractors to become practice educators will increase. This standard signals the importance given to developing and supporting others by promoting and engaging in their professional learning. 'be prepared to contribute..' is used to ensure that the requirement is proportionate, recognising that the varied settings and roles that chiropractors work in will impact upon the opportunities and ability that they have to promote and engage in the learning of others. It does not mean that every chiropractor must act as an educator. The inclusion of mentoring addresses the issue of providing support for new graduates. The new standard addresses the concerns of stakeholders, the changing requirements for clinical experiential learning, and also updates the Code in line with the standards of other health regulators.

Principle I
You must maintain, develop and work within your professional knowledge and skills

Code 2016:	*Principle G:* *Maintain, develop and work within your professional knowledge and skills*
What has changed?	Principle I is unchanged

Introduction to Principle I:

Chiropractic practice is a lifelong journey that demands continuous growth and the upkeep of skills and knowledge to remain current with advancements in the profession. Chiropractors are required to work within their own individual scope of practice. They are expected to regularly monitor the need to adapt and update their practice, taking responsibility for remaining up to date, and for further developing and improving their professional performance.

What has changed?	The introduction to Principle I sets out how it represents core shared values: **Safety and Quality; Professionalism.**

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.
Code 2016:	*New standard*
What has changed?	There is a new requirement to continuously monitor how you practice, through reflection, in the interest of enhancing the care and safety of your patients.
Why has this change been made?	Professionalism, and Safety and Quality are core shared values between patients and chiropractors. These are underpinned by taking responsibility for maintaining and enhancing competence in practice. I1,and I3 have been introduced, along with amendments to I2 and I4, to set out the essential professional behaviours that support this. Our stakeholders told us that the requirement for reflective practice was missing from the Code. Reflective practice is an important tool for personal development and is included in our Education Standards. The amendment addresses the gap identified by our stakeholders and brings the Code up to date with our Education Standards."
See also:	• Joint Regulatory Statement: Benefits of becoming a reflective practitioner - https://www.gcc-uk.org/assets/publications/Benefits_of_becoming_a_reflective_practitioner_-_joint_statement_2019.pdf

I2	regularly consider how to adapt or improve your practice considering new developments, technologies and evidence from research.
Code 2016:	**G1** *keep your knowledge and skills up to date, taking part in relevant and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance and the quality of your work*
What has changed?	There is a new requirement to routinely think about and identify how to adapt and improve your practice. We specify that keeping "up to date" refers to new developments, technologies and evidence.
Why has this change been made?	The need to continuously adapt and improve one's own practice in response to change is fundamental to keeping up to date. The amendments emphasise the importance of proactively looking for areas where adaptation or improvement is indicated. They also clarify that keeping "up to date" means with new developments, technologies and evidence.

I3	routinely seek and critically appraise emerging evidence. You must integrate findings of the best quality of evidence that is available at the time into your practice, to enhance the care of patients.
Code 2016:	*New standard*
What has changed?	There is a new requirement to proactively identify and appraise relevant best quality evidence and to integrate the findings of this into your practice.
Why has this change been made?	Patients told us that they expected that chiropractors, along with all healthcare professionals, would keep up to date with, and use the best current evidence. This is included in our Education Standards, but is not fully captured in the 2016 Code. The new Standard sets out clearly the expectation that chiropractors keep themselves up to date with emerging evidence that is relevant to practice, establish the quality of evidence through critical appraisal, and ensure that they put into practice the findings of the best quality evidence. The amendments meet the expectations of our stakeholders and address the gap in the Code (2016) to bring it in line with our Education Standards. The amendments also align with frameworks that set out competencies for junior and established practitioners in healthcare more widely.
See also:	For details on recommended junior practitioner ("awareness" level) and established practitioner ("core" level) research competencies, to support evidence-based practice, see: • Council for Allied Health Professions in Research (CAHPR) Research Practitioner Framework (Harris et al, 2019) - https://cahpr.csp.org.uk/system/files/documents/2019-11/Shaping Better Practice Through Research A Practitioner Framework.pdf For further explanation about the definition and principles of Evidence-based medicine, including the critical appraisal of evidence: • Evidence-based Medicine: How to Practice and Teach EBM (Sackett et al, 2000) - https://www.amazon.co.uk/Evidence-Based-Medicine-How-Practice-Teach-dp-0702062960/dp/0702062960/ref=dp_ob_title_bk

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.	
Code 2016:	**G1**	*keep your knowledge and skills up to date, taking part in relevant and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance and the quality of your work.*
What has changed?	“Knowledge and skills” has been re-framed as “competence and performance”. There is a new requirement to be competent in all aspects of professional work, not limited to clinical practice.	
Why has this change been made?	Our stakeholders told us that the Code was focussed on clinical practice but should also set out standards for chiropractors engaged in other roles, such as education or research. The amendments broaden the requirements of professional competence to also include non-clinical roles. We recognise that the level for competence (having the skills or knowledge to do something well enough to meet a basic standard) will be relative to requirements of the role. This does not mean that formal qualifications are always required. The amendment updates the Code to meet the expectations of our stakeholders.	

I5	recognise and work within the limits of your own knowledge, skills and competence. You must be clear with the patient about your limits.	
Code 2016:	**G3**	*recognise and work within the limits of your own knowledge, skills and competence.*
	G4	*make clear the limits of your competence and knowledge to patients.*
What has changed?	G3 (2016) and G4 (2016) have been merged. Minor additional re-wording amendment	
Why has this change been made?	Merging the standards reduces duplication.	

I6	recognise the roles and expertise of other chiropractors and healthcare professionals. You must refer to them, or seek their expertise, when needed.
Code 2016:	**G5** *refer to, or seek expertise from, other chiropractors or healthcare professionals, when needed.*
What has changed?	There is an expanded requirement to recognise where the expertise of other chiropractors or healthcare professionals may lie, with respect to your own.
Why has this change been made?	Our stakeholders, including patients, told us that chiropractors must understand the roles and expertise of other healthcare professionals, understand care pathways, and recognise where another healthcare professional may be better placed to provide the care that a patient needs. The amendment updates the Code to better meet the expectations of patients, and in line with our Education Standards.

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.
Code 2016:	**G6** *not require anyone else to take on responsibilities for patient assessment and care where it would be beyond their level of knowledge, skills or experience.*
What has changed?	“Not require” has been changed to “do not allow” another person to take on responsibility for patient care without sufficient knowledge, skills or experience.
Why has this change been made?	Safety and Quality is a core shared value between patients and chiropractors. Ensuring that patients are only ever assessed or cared for by suitably competent individuals plays an important role in protecting patient safety. The amendment strengthens the requirement of the 2016 Code, setting out a more active duty for chiropractors to prevent potentially unsafe patient care by others. The amendment provides greater protection of patients.

Principle J
You must maintain and protect information about patients

Code 2016:	*Principle H:* *Maintain and protect patient information*
What has changed?	Principle J is unchanged Standards that comprise this Principle have been removed where they set out duties that are legal obligations, as this is captured more broadly within C4.

Introduction to Principle J:

Chiropractors are responsible for the personal information they collect and hold on their patients. They must fulfil their duties, as set out in legislation, for the protection of data. They need to be clear about the lawful basis for the disclosure or processing of data, giving access to it where this is required.

Advances in technology pose new risks to the personal information of patients. Chiropractors hold responsibility for keeping up to date with advancing technology in their practice and for taking positive action to prevent improper disclosure or misuse of information about a patient.

Chiropractors are accountable for ensuring that they maintain the health record for each patient, recording the status of their health, and each interaction with them. They are also responsible for ensuring the proper storage, transfer and eventual destruction of patient health records.

What has changed?	The introduction to Principle J sets out how it represents core shared values: **Safety and Quality; Professionalism.**

J1	adapt to advancing technology, including data sharing, media sharing and social media, to proactively protect the patient's personal information.	
Code 2016:	**H1**	*keep information about patients confidential and avoid improper disclosure of their personal information.*
What has changed?	Broader requirements of H1 (2016) have been removed, as these are legal requirements and, as such, the duty to comply with these is captured in C4. There is a new, more specific requirement to adapt to advancing technology, including data sharing, media sharing and social media, to proactively protect the patient's personal information.	
Why has this change been made?	Our stakeholders told us that the existing Code did not explicitly enough address the use of newer, rapidly developing technologies. The amendment emphasises the need to keep abreast of new technologies and emerging issues and to take appropriate action to prevent breaches in the protection of patient information, before they occur. The amendment addresses the concerns identified by our stakeholders and updates the Code in line with developments in the use of technology (current and future) and the approaches of other healthcare regulators.	

See also:	• Information Commissioner's Office. Guide to the General Data Protection Regulation (GDPR). 2018: https://ico.org.uk/about-the-ico/what-we-do/legislation-we-cover/general-data-protection-regulation/

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.	
Code 2016:	**H3**	*ensure your patient records are kept up to date, legible, attributable and truly representative of your interaction with each patient.*
What has changed?	There is an additional requirement to clearly identify retrospective changes to patient records.	
Why has this change been made?	The amendment clarifies requirements around retrospectively amending records.	

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).	
Code 2016:	**H4**	*ensure the safe storage of patient records so that they remain in good condition and are kept secure. Storage should be for at least a period relevant to the age of the patient as prescribed by law.*
What has changed?	There is additional specification setting out that the requirement for safe secure storage applies whether storage is physical or digital.	
Why has this change been made?	The amendment emphasises that the safe storage of records applies to digital, as well as physical systems. This updates the Code in line with developments in technology.	

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.	
Code 2016:	**H5**	*make proper arrangements if you close down your practice or move clinics and have appropriate arrangements in place in the event of your death.*
What has changed?	We have specified that “proper arrangements” refers to protecting or transferring patient records.	
Why has this change been made?	The amendment clarifies that this standard is about patient records. This is not specified in the 2016 Code.	

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.	
Code 2016:	**H6**	*make sure that patient records remain your responsibility, even where a patient has moved, unless you have contractually transferred this responsibility to another healthcare professional or organisation.*
What has changed?	“Make sure” has been changed to “ensure”.	
Why has this change been made?	The minor linguistic change is more consistent with the formal language of the Code, conveying the requirement for a proactive approach to be taken.	

General Chiropractic Council
Park House
186 Kennington Park Road
London
SE11 4BT
T: +44 (0) 020 7713 5155
E: enquiries@gcc-uk.org
W: www.gcc-uk.org

This document is also available in Welsh.

Published December 2024