Code of Professional Practice:

Mapping to Code 2016

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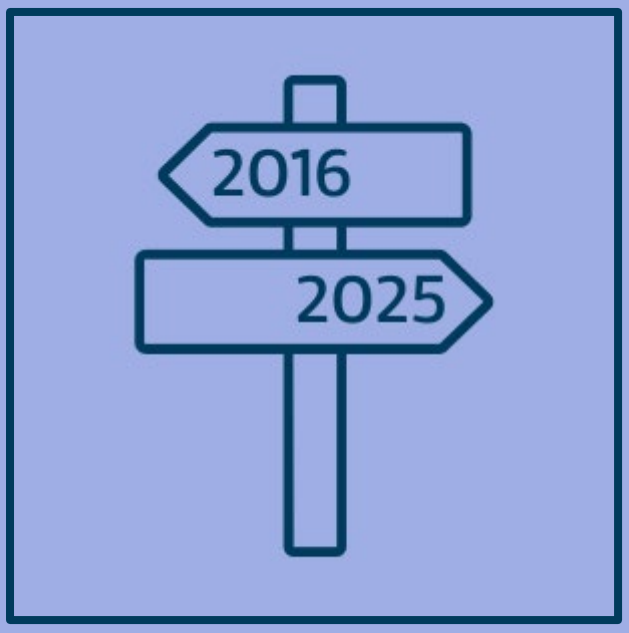

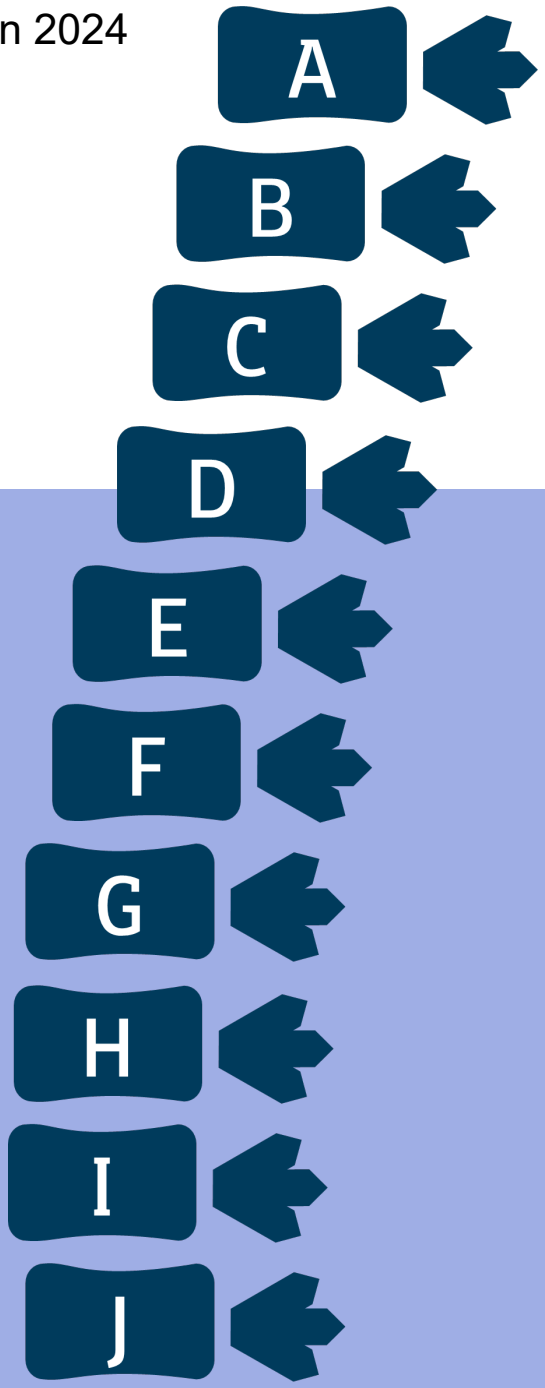

This document sets out the changes between the current Code (2016) and the proposed Code of Professional Practice. It also sets out to explain in brief terms what we are proposing to change, and why. Where appropriate it also references other materials that may be relevant to the change.

Contents

Principle A
Put the interests of patients first

Code 2016:	*Principle A:* *Put the health interests of patients first*
What are we proposing to change?	The removal of "health" broadens Principle A to all aspects of patient interests.
Why are we proposing this change?	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 care and **safety** of every patient is 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. Chiropractors listen to each patient, help them to be involved in reaching decisions about their care, provide care that is personalised to their needs and empower them in their care, health and wellbeing.

What are we proposing to change?	The introduction to Principle A sets out how it represents core shared values: Patient-centred Care; Safety and Quality
Why are we proposing this change?	This better reflects the fact that Principle A extends beyond health interests.

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 are we proposing to change?	We have rephrased A5 to provide a broader standard as the foundation to Principle A.	
Why are we proposing this change?	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.	
See also:	• GCC toolkit: Patient-centred care - https://www.gcc-uk.org/assets/downloads/GCC_Toolkit_Patient_Centred_Care_2_(1).pdf	

A2	Show respect, compassion, and care for the patient: ask what matters to them and consider their needs and preferences; respond honestly and openly to their questions. Do not put any pressure on a 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 are we proposing to change?	We have made linguistic changes that emphasise the need for chiropractors 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 are we proposing this change?	These amendments will update the Code in line with other regulators and with feedback that patients gave us

A3	Engage effectively with the patient through person-centred conversations and interactions.
Code 2016:	*New standard*
What we are proposing to change?	Three new standards (A3, A4 and A5) set out the 3 main steps of patient-centred care, as defined in Person-centred Approaches (2017). A3 introduces a new requirement - ensuring that every patient is treated as an individual throughout their care.
Why we are proposing this change?	Patient-centred care is a core shared value between patients and chiropractors. The 2016 Code pre-dated clear definitions of patient-centred care. 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. These amendments will update the Code in line with best practice developments in healthcare (person-centred approaches), the professional standards of other regulators, and with what stakeholders told us.
See also:	• Skills for Health - person centred approaches: https://www.skillsforhealth.org.uk/resources/person-centred-approaches-2017/

A4	Support the patient with their care, health and wellbeing. Involve them in decisions about their care.
Code 2016:	*New standard*
What we are proposing to change?	A4 introduces a new requirement, concerned with empowering the patient. It also addresses shared decision-making.
Why we are proposing this change?	Patients 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 that enables them to take control of their conditions. A further finding was that patients want to be involved in the decisions around their care. Shared decision-making was identified by stakeholders as important and somewhat, but not fully, reflected in the 2016 Code. These amendments will update the Code in line with what stakeholders told us, with best practice developments in healthcare (person-centred approaches) 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 • GCC Public Perceptions Report 2021: https://www.gcc-uk.org/assets/downloads/Public_Perceptions_Research_report,_February_2021.pdf

A5	Collaborate with the patient's family, advocates, carers, and health and care professionals to support the patient - particularly when they have complex health or social circumstances.
Code 2016:	*New standard*
What we are proposing to change?	A5 is a new standard that is about making 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 we are proposing this change?	Patients told us that they expected that their chiropractor would work with others who are involved in their care. Collaborative practice is not included in the 2016 Code. This updates the Code in line with best practice developments in healthcare (both person-centred approaches and collaborative healthcare), with the professional standards of other regulators and with patients' expectations.
See also:	• Skills for Health - person centred approaches: *https://www.skillsforhealth.org.uk/resources/person-centred-approaches-2017/*

A6	Respect the patient's privacy, dignity and their right to choose who is in the room when their care is provided.
Code 2016:	**A2** *respect patients' privacy, dignity and cultural differences and their rights prescribed by law.*
What we are proposing to change?	Respecting cultural differences has been moved to A7 Respecting patients' rights prescribed by law has been removed (it is captured in A7 and C3) The right of the patient to choose who is in the room when their care is provided is added, with respect to maintaining privacy and dignity.
Why we are proposing this change?	Amendments reduce duplication within the Code. The right to choose who is in the room 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.
See also:	• Standard A7 – Treat the patient fairly and without discrimination. Interact with them in a way that respects their individual choices, diversity and culture. • Standard C3 – Take responsibility, as an autonomous healthcare professional, for keeping up to date with, and following: legislation; GCC guidance; regulations; and codes of practice from other regulators. • Community Research Code Conversation Event Feedback Report - https://www.gcc-uk.org/assets/publications/Code_Conversation_Event_Feedback_Report_June_2024.pdf

A7	Treat the patient fairly and without discrimination. Interact with them in a way that respects their individual choices, diversity and culture.
Code 2016:	**A4** *treat patients fairly and without discrimination and recognise diversity and individual choice.*
What we are proposing to change?	Replacing "recognise" with "interact with them in a way that respects..." There is a new inclusion of culture, in addition to individual choices and diversity.
Why we are proposing this change?	The 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. The amendments also update the standards in line with those of other healthcare regulators.
See also:	• GCC Equality, Diversity and Inclusion Toolkit - https://www.gcc-uk.org/assets/downloads/GCC_EDI_Toolkit_FINAL_(Web_edition).pdf

<table>
<tr><td>A8</td><td colspan="2">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, promptly follow the established local safeguarding arrangements to report your concern; and record your suspicions and actions.</td></tr>
<tr><td>Code 2016:</td><td>A7</td><td>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.</td></tr>
<tr><td>What we are proposing to change?</td><td colspan="2">The 2016 standard requires you to fulfil legal obligations and to report safeguarding concerns. 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</td></tr>
<tr><td>Why we are proposing this change?</td><td colspan="2">This is in line with the strengthened expectations of other healthcare regulators, in the interest of protecting children and vulnerable adults.</td></tr>
<tr><td>See also:</td><td colspan="2">Standard C3 – Take responsibility, as an autonomous healthcare professional, for keeping up to date with, and following: legislation; GCC guidance; regulations; and codes of practice from other regulators.</td></tr>
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Principle B
Ensure safety and quality in clinical practice

Code 2016:	*New Principle*
What are we proposing to change?	This is a new Principle, focussed on practice systems that ensure quality, safety and accessibility. It is about practice governance. Some Standards in the 2016 Code 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 are we proposing this change?	This is a new Principle, introduced to address areas identified by our stakeholders as key gaps in the Code. Safety in healthcare and also in chiropractic are global priorities of the World Health Organisation (WHO) and the World Federation of Chiropractic (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. 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:

Robust systems of safety in practice help keep patients safe. These should promote **safety**, in the interest of preventing harm, before harm occurs. Prevention requires **transparent** reporting of safety incidents by chiropractors, enabling learning to occur and action to be taken to reduce future risks to patients. Chiropractors must be prepared to respond to emergencies in practice. Chiropractors 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 take reasonable measures to address these in practice.

Assuring the **quality of care** provided is central to the protection of patients. This requires chiropractors to implement robust methods for continuous improvement in the quality of care they provide to patients.

What are we proposing to change?	The introduction to Principle B sets out how it represents core shared values: **Safety and Quality.**

B1	Promote and maintain a culture of safety, to try to prevent harm before it occurs.
Code 2016:	*New Standard*
What are we proposing to change?	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 are we proposing this change?	This brings the Code in line the expectations of our stakeholders, with our new Education Standards, and with the standards of other regulators.

B2	When you have concerns about the safety of a patient, act promptly and appropriately, and record what you did.	
Code 2016:	**A3**	*Take appropriate action if you have concerns about the safety of a patient.*
What are we proposing to change?	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 are we proposing this change?	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. Ensure all equipment you use is safe and meets relevant regulatory standards. Plan for emergencies and follow those plans when an emergency happens.	
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 are we proposing to change?	We have imported Standards A6 and C9 from the 2016 Code and combined them within new Principle B. We have broadened “treat patients in...” to “practice in...” We have specified an additional active requirement to “identify and control risks”. We have also added a new requirement to have in place plans, in case of emergencies arising, and that these are followed, if needed.	
Why are we proposing this change?	The amendments strengthen your practice 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. The new requirement to plan for and follow appropriate procedures in the event of an emergency sets out the duty for practice governance to protect patients. This would include medical emergencies. This brings the requirements in line with the standards of other regulators.	
See also:	• GCC Guidance on First Aid in Emergencies - https://www.gcc-uk.org/assets/publications/GCC-Guidance-First_Aid_Updated_May_2021.pdf	

B4	Recognise the importance of promoting accessible healthcare for all patients, and support this in your practice.
Code 2016:	*New Standard*
What are we proposing to change?	We have added a new requirement for you to support accessible healthcare in your practice. This will necessitate identifying barriers and taking *reasonable* measures to address these, so that all patients have equitable access to healthcare via your practice (see glossary for examples)
Why are we proposing this change?	Access to healthcare is a key factor in health outcomes for people. The new Education Standards address this, but the 2016 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.

B5	Recognise safety incidents and "near misses" that threaten the safety of a patient or another person. When you identify an incident or near miss, report it through a suitable safety system, so that you, and the wider profession, can learn from it.
Code 2016:	*New Standard*
What are we proposing to change?	We have introduced new requirements for your proficiency and the actions that you take in relation to the principles of safety incident (and “near miss”) recognition and reporting. There is a new duty for you to report safety incidents, through a suitable reporting system. A suitable reporting system will be one that permits the wider profession, as well as yourself, to learn from the incident.
Why are we proposing this change?	Our stakeholders told us that engagement with safety systems was an important part of assuring wider patient safety and a key omission in the existing Code. This is an essential part of avoiding preventable future harms. Research conducted by the GCC (Registrant Survey, 2020) identified that there was variation in engagement with safety incident reporting systems in practice. The standard recognises that the means of reporting incidents may vary, depending upon the practice setting, but that a profession-wide safety system does exist (see links) The addition of the new standard brings the Code in line with our 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/

B6	Collect appropriate feedback, quality and other indicators to evaluate the quality of care of your patients. Apply quality management principles to continuously improve: your practice, your wider team practice, and service delivery.
Code 2016:	*New Standard*
What are we proposing to change?	We have introduced new requirements for governance in relation to the quality of your care of patients and also the quality of the wider practice or service within which you work. 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 are we proposing this change?	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
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 are we proposing to change?	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.

Professionalism also includes managing one's own health and wellbeing, and the expression of personal views, with respect to interactions with patients and others. It also includes wider responsibilities as a regulated healthcare professional, including the duty to take action when you witness unprofessional behaviour by others.

What are we proposing to change?	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. 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 are we proposing to change?	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 are we proposing this change?	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. This updates the Code in line with the standards of other regulators.	

C2	Ensure that you, and anyone that has a chiropractic qualification and works with you, is registered with a statutory UK health regulator and has appropriate insurance and indemnity cover for their full scope of practice. Be clear with the patient that you are registered with the General Chiropractic Council.
Code 2016:	**B2** *Ensure you, and any chiropractor who works with you on a contractual basis, are properly qualified, registered and insured.*
What are we proposing to change?	We have added clarification that "any chiropractor" means anyone with a chiropractic qualification.
Why are we proposing this change?	The language in the 2016 Code 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. 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.

C3	Take responsibility, as an autonomous healthcare professional, for keeping up to date with, and following: legislation; GCC guidance; regulations; and codes of practice from other regulators.
Code 2016:	**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.*
What are we proposing to change?	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 are we proposing this change?	These amendments clarify your professional responsibility to make sure that you know of, and apply key legislation, GCC guidance, Codes of practice from other regulators etc. For example, this will include, but is not limited to, the ASA/CAP, IRMER, all GCC guidance, all relevant statutory frameworks and guidance etc. This is in line with the expectations of other regulators.
See also:	• Standard C4 - When telling people about your services, ensure that all information is factual, verifiable, not misleading, and does not exploit their vulnerability, or lack of health knowledge.

C4	When telling people about your services, ensure that all information is factual, verifiable, not misleading, and does not exploit their vulnerability, or lack of health knowledge.
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 are we proposing to change?	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 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 C3)
Why are we proposing this change?	The focus on the 2016 Code is on meeting requirements of the ASA, 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. C3 covers the requirement to comply with the ASA's CAP Code
See also:	• Standard C3 - Take responsibility, as an autonomous healthcare professional, for keeping up to date with, and following: legislation; GCC guidance; regulations; and codes of practice from other regulators. • GCC Advertising Guidance - https://www.gcc-uk.org/i-am-a-chiropractor/guidance/toolkits-and-guidance

C5	Ensure the credibility of any health information that you share, demonstrating transparency, and accountability: information must be evidence-based, and accessible to its intended audience.
Code 2016:	*New Standard*
What are we proposing to change?	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 are we proposing this change?	Our stakeholders told us the 2016 Code was 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:	• 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 information - https://service-manual.nhs.uk/content/standard-for-creating-health-content

C6	Behave with integrity, act professionally, and honestly, upholding the reputation of the profession and justifying public trust, in all aspects of your life.	
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 are we proposing to change?	"Patient trust" has been widened, to "public trust". "Including outside the workplace" has been widened to "at all times".	
Why are we proposing this change?	The amendments recognise 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.	

C7	Maintain patient confidentiality, and dignity, at all times including online, during remote consultations, and when referring to patients 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 are we proposing to change?	The need to maintain patient "dignity" has been specified, in addition to the need to maintain "confidentiality". "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 are we proposing this change?	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 2016 Code 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.	
See also:	• GCC Confidentiality Guidance - https://www.gcc-uk.org/assets/publications/GCC_Guidance_Confidentiality_(2018)_(Rebranded_Oct_2021).pdf • GCC Social Media and Messaging Guidance - https://www.gcc-uk.org/assets/downloads/GCC_Social_Media_and_Messaging_Guidance_18_October_2021_(Final).pdf	

C8	Be honest, fair, and transparent in your business. Your recommendations and care for a patient must not be detrimentally affected by any personal, financial or commercial interest. Do not ask for, accept, or offer, any inducement that may detrimentally affect the care of a patient.
Code 2016:	*New Standard*
What are we proposing to change?	We have introduced this new, broad standard addressing business probity, conflicts of interest and inducements
Why are we proposing this change?	Honesty, integrity and transparency is 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 2016 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

C9	Determine and share a clinical plan of care for the patient separately (and independently) from any financial payment plan. Provide a clear contract for any financial payment plan which must include arrangements for refunds for unused care. Do 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. Do 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 are we proposing to change?	We have expanded B6 (2016), providing additional detail of our expectations around financial payment plans. 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 treatment is unacceptable.	
Why are we proposing this change?	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 Fitness to Practise (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).	

C10	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. 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 are we proposing to change?	Minor linguistic amendments have been made. There is also clarification that the explanation following something going wrong with care needs to include an account of actions taken as a result of this, to remedy both the issue and to prevent future harm.	
Why are we proposing this change?	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:	• GCC Candour Guidance - https://www.gcc-uk.org/assets/publications/Candour_Guidance_2023.pdf • Joint Regulatory Statement: Duty of Candour - https://www.gcc-uk.org/assets/publications/Joint_statement_on_the_professional_duty_of_candour.pdf	

C11	Ensure your personal biases, values and beliefs do not detrimentally impact the care that you provide to the patient, your personal interactions, or your reputation.
Code 2016:	*New Standard*
What are we proposing to change?	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 are we proposing this change?	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.
See also:	• GCC Equality, Diversity and Inclusion Toolkit - https://www.gcc-uk.org/assets/downloads/GCC_EDI_Toolkit_FINAL_(Web_edition).pdf

C12	Raise concerns about colleagues if you believe they are treating people unfairly, have discriminated against someone or if their personal biases have detrimentally impacted the care they provide. Raise concerns following the relevant procedures and maintaining the safety of everyone involved.
Code 2016:	*New Standard*
What are we proposing to change?	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 are we proposing this change?	Our stakeholders told us that EDI could be strengthened. Wider developments in the expectations of healthcare professionals, since the publication of the 2016 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 currently. By taking action and raising concerns you prevent unfair or discriminatory practices from occuring, rather than allowing them 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.
See also:	• GCC Equality, Diversity and Inclusion Toolkit - https://www.gcc-uk.org/assets/downloads/GCC_EDI_Toolkit_FINAL_(Web_edition).pdf

C13	Justify and record your reasons for refusing or discontinuing care for a patient. Explain, in a fair and unbiased way, how they can find other healthcare professionals who could offer care. Do not unreasonably deny a patient access to care that meets their needs.	
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 are we proposing to change?	An additional clause is added to the existing standard "Do not unreasonably deny a patient access to care that meets their needs".	
Why are we proposing this change?	The amendment makes explicit the patient's right to care, in line with wider UK healthcare professions.	

C14	If you have concerns about your own fitness to practise, whether due to issues with health, character, behaviour, judgement or any other matter which may compromise patient safety or damage the reputation of your profession, stop practising immediately and seek appropriate advice.
Code 2016:	*New Standard*
What are we proposing to change?	This new standard sets out your responsibility to evaluate your own fitness to practice, and to act promptly should this fall short, for any reason.
Why are we proposing this change?	By adding this new standard, we are being clear of your responsibility as an autonomous healthcare professional, and that you are expected to stop practising if you doubt your fitness to practice. This entails seeking appropriate help and making adjustments, if indicated. This is related to C1, however whereas C1 is about acting where others are placed at risk, C14 is about acting where your fitness to practice may be impaired.
See also:	• Standard C1 - Look after your health and wellbeing…

<table>
<tr><td>C15</td><td colspan="2">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).</td></tr>
<tr><td>Code 2016:</td><td>B9</td><td>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.</td></tr>
<tr><td>What are we proposing to change?</td><td colspan="2">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 added clarification that the threshold for informing the GCC around “criminal proceedings” means where 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.</td></tr>
<tr><td>Why are we proposing this change?</td><td colspan="2">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.</td></tr>
</table>

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. Respond to all reasonable requests from the GCC. If you are informed that you are the subject of a GCC investigation, follow any 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 are we proposing to change?	The final clause of B9 (2016) has been expanded in C16. We have added the requirement that your cooperation with investigations etc must be "prompt". 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 are we proposing this change?	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
Provide a good standard of clinical care and professional practice

Code 2016:	*Principle C:* *Provide a good standard of clinical care and practice*
What are we proposing to change?	"Clinical care and practice" has been amended to "clinical care and professional practice"
Why are we proposing this change?	This broadens Principle D to include engagement with research, that might extend beyond your clinical practice.

Introduction to Principle D:

A chiropractor provides 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 underpinning clinical approaches and that evidence of the best available quality is integrated throughout the care of patients. Packages of care that adhere to the recommendations of relevant clinical guidelines, within the scope of chiropractic practice, should be offered. A chiropractor must have sound justification for their clinical recommendations and decisions about care.

Developments in professional practice include new technologies and ways of working, that bring benefits to patient care but might involve some risk. Chiropractors must engage with these to promote safety and effectiveness.

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

What are we proposing to change?	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 are we proposing to change?	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 are we proposing this change?	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	Determine the patient's goals of care. Before commencing care, agree (and record) with the patient how you will use evidence-based outcome measures to demonstrate their progress towards the planned health outcomes.
Code 2016:	*New Standard*
What are we proposing to change?	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. Measures must be evidence-based.
Why are we proposing this change?	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 evidence-based. (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.

<table>
<tr><td>D3</td><td colspan="2">Carry out a physical examination of the patient using methods supported by the best available evidence. You must fully explain to the patient (and record) the results of the examination.</td></tr>
<tr><td>Code 2016:</td><td>C2</td><td>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.</td></tr>
<tr><td>What are we proposing to change?</td><td colspan="2">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 A1, and A6, respectively.</td></tr>
<tr><td>Why are we proposing this change?</td><td colspan="2">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 relevant 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 select 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.</td></tr>
<tr><td>See also:</td><td colspan="2">• Standard A1 - Put the patient's needs and safety at the centre of their care.
• Standard A6 - Respect the patient’s privacy, dignity and their right to choose who is in the room when their care is provided.</td></tr>
</table>

D4	Ensure that you have the informed consent of the patient for any diagnostic investigation (including imaging) before it is carried out. Carry out investigation in the best interests of the patient and in a way that minimises the risks to them. Base the investigation on clinical reasoning, following 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 are we proposing to change?	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 evidence-based guidelines. The detail around recording the rationale and outcomes of investigations has been removed.	
Why are we proposing this change?	Stakeholders told us that the relationship between the Code and the GCC Guidance: 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: Diagnostic Imaging	
See also:	• GCC Registrant Guidance: Diagnostic Imaging - https://www.gcc-uk.org/assets/downloads/Diagnostic_Imaging_Guidance_March_2022.pdf • 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 fully 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 are we proposing to change?	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 fully informed, to include indicating diagnostic uncertainty	
Why are we proposing this change?	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.	

<table>
<tr><td>D6</td><td colspan="2">In partnership with the patient use:
the findings of the clinical assessment
the best available evidence
the patient’s needs and priorities
to propose (and record) a personal 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.</td></tr>
<tr><td>Code 2016:</td><td>C4</td><td>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.</td></tr>
<tr><td>What are we proposing to change?</td><td colspan="2">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 D8) specifying our expectations for how you develop a plan of care.

We specify that your plan of care is personalised to the patient and developed in partnership with them.

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.</td></tr>
<tr><td>Why are we proposing this change?</td><td colspan="2">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.

The amendments strengthen the requirement for you to work in partnership with each patient, rather than only gaining their “agreement”, as is specified in the 2016 Code.

This standard is also 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 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.</td></tr>
<tr><td>See also:</td><td colspan="2">• Standard I5 - Recognise and work within the limits of your own knowledge, skills and competence. Be clear with the patient about your limits.</td></tr>
</table>

D7	Inform the patient of the risks, benefits and alternatives to the proposed plan of care, including evidence-based options 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 are we proposing to change?	We have combined and amended E1 and F1 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 are we proposing this change?	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	In partnership with the patient, develop, record and implement a plan of care that is person-centred and evidence-based. 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 the consent of the patient before implementing the plan of care. Do not propose a plan of care 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 are we proposing to change?	We have included greater detail in D8 (see also D6) specifying our expectations for how you develop a plan of care. 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 (D1-4) and relevant subsequent reassessments (D9). We have added clarification that the consent of the patient must be obtained before the plan of care is implemented.	
Why are we proposing this change?	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 Fitness to Practise (FtP) issues that have arisen by providing clarity on what is, or is not, acceptable.	
See also:	• Standard D2 - Determine the patient's goals of care… • Standard D6 - In partnership with the patient use…to propose (and record) a personal plan of care for the patient…. • Standard D9 - Continuously monitor (and record) the patient's progress… • Standard D10 - The patient must consent to any continuation or modification…	

D9	Continuously monitor (and record) the patient's progress, evaluating and adapting the plan of care to meet their needs. Carry out formal reviews at regular intervals, pre-agreed with the patient. Use evidence-based outcome measures to evaluate the effectiveness 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 are we proposing to change?	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 outcome measures that are evidence-based (following on from D2).	
Why are we proposing this change?	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 evidence-based outcome measures will have been determined. The amendments address concerns raised by stakeholders, and Fitness to Practise (FtP) issues that have arisen.	
See also:	• Standard D2 - Determine the patient's goals of care… • Standard D8 - In partnership with the patient, develop, record and implement a plan of care that is person-centred and evidence-based…	

D10	The patient must consent to any continuation or modification to the plan of care following a discussion with you considering how they are progressing towards their planned health outcomes. Record that discussion.	
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 are we proposing to change?	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 "consent". We have removed the specific reference to ceasing care.	
Why are we proposing this change?	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 (D9 and D10). The amendments meet the expectations of stakeholders and update the Code in line with good healthcare practice and the requirements of other regulators.	
See also:	• Standard D2 - Determine the patient's goals of care… • Standard D9 - Continuously monitor (and record) the patient's progress…	

<table>
<tr><td>D11</td><td colspan="2">Use evidence-based practice to select and implement safe, appropriate, chiropractic care that meets the needs and preferences of the patient; this may include:
manual techniques,
rehabilitative interventions,
and psychologically informed approaches.
Encourage and support patients to self-manage their health, signposting them to relevant resources.</td></tr>
<tr><td>Code 2016:</td><td>C5</td><td>Select and apply appropriate evidence-based care which meets the preferences of the patient at that time.</td></tr>
<tr><td>What are we proposing to change?</td><td colspan="2">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 your chiropractic care includes manual techniques, rehabilitative interventions and psychologically informed approaches

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.</td></tr>
<tr><td>Why are we proposing this change?</td><td colspan="2">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 2016 Code, whereby it does not indicate what chiropractic care approaches are.

The amendment outlines the range of approaches that you use in your chiropractic care. 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</td></tr>
<tr><td>See also:</td><td colspan="2">GCC Education Standards - 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</td></tr>
</table>

D12	With the informed 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 are we proposing to change?	We are merging content from C6 (2016) and C7 (2016) around referrals, into a single new standard (D12).	
Why are we proposing this change?	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.	
See also:	• Standard I6 - Recognise the roles and expertise of other chiropractors and healthcare professionals. Refer to them, or seek their expertise, when needed. • Standard G4 - Communicate effectively with other professionals; in the interest of meeting the patient's health and care needs and goals; sharing information with the consent of the patient. • Standard H1 - Enhance the integrated care of the patient by collaborating effectively with other health and care professionals.	

D13	Engage in evidence-based prevention and health promotion interventions to support the physical, mental and social wellbeing of individuals and the population, while considering health inequalities. Support public health initiatives to enhance the health and wellbeing of others.
Code 2016:	*New Standard*
What are we proposing to change?	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. We have introduced a new requirement of you to support public health initiatives.
Why are we proposing this change?	The need to engage in prevention and health promotion, in line with public health initiatives, was identified by our stakeholders as a gap in the existing Code. 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 scope of practice as a chiropractor and might, for example include, providing information or signposting patients to further resources. 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	With the consent of the patient, use digital technologies to enhance practice. Ensure care is effective and safe whether it is provided face-to-face or remotely.
Code 2016:	*New Standard*
What are we proposing to change?	This standard sets out new requirements for how digital technologies are used in practice.
Why are we proposing this change?	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 “digital technologies”). 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	Engage with research ethically and effectively: this may include promoting or conducting research, and the use of research in practice.
Code 2016:	*New Standard*
What are we proposing to change?	This broad standard sets out new requirements for how you engage with research.
Why are we proposing this change?	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 in 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
Establish and maintain clear professional boundaries

Code 2016:	*Principle D:* *Establish and maintain a clear professional relationship with patients*
What are we proposing to change?	"Relationship with patients" has been amended to "boundaries".
Why are we proposing this change?	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. Patients are protected when their chiropractor ensures that their interactions are confined within the limits set by proper boundaries for the **professional** relationship. This enables care to be provided in effective partnership with the patient, upholding trust, respect and dignity, and always acting in the best interest of the patient.

Code 2016:	
What are we proposing to change?	The introduction to Principle E sets out how it represents core shared values: Safety and Quality; Professionalism; Honesty, Integrity and Transparency.
Why are we proposing this change?	This introduction links Principle E to the core values.

E1	Recognise the power imbalance between you as a healthcare professional and the patient. Do not abuse your position of power and trust in any interaction with the patient. Do not cross, pursue or encourage the crossing of sexual, emotional or financial boundaries.
Code 2016:	**D1** *Not abuse the position of trust which you occupy as a professional. You must not cross sexual boundaries.*
What are we proposing to change?	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" and added that this applies in any interaction with the patient. We have broadened the standard from "sexual boundaries" only, to "sexual, emotional or financial boundaries".
Why are we proposing this change?	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 Fitness to Practise (FtP) data also supported this. The amendments signal that improper relationships are not confined to the crossing of sexual boundaries. There is also a new standard of proficiency requirement to recognise the role of power imbalances. 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.
See also:	• GCC Guidance: Maintaining Sexual Boundaries - https://www.gcc-uk.org/assets/publications/Maintaining_Sexual_Boundaries_Guidance_2016.pdf • GCC Guidance: Social media and messaging - https://www.gcc-uk.org/assets/downloads/GCC_Social_Media_and_Messaging_Guidance_18_October_2021_(Final).pdf

E2	Ensure you, and the staff you employ, treat the patient, their carer and anyone accompanying them, with equal 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 are we proposing to change?	We have removed "be professional at all times" (captured in C6). "Treat all patients" has been expanded to "treat all patients, their carers or others accompanying them".
Why are we proposing this change?	This minor amendment will 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 2016 Code.
See also:	• Standard C6 - Behave with integrity, act professionally, and honestly, upholding the reputation of the profession and justifying public trust, in all aspects of your life.

E3	If there is a clinical need for an item of clothing to be removed, explain the reason to the patient and obtain and record informed consent; offer them privacy to undress and the use of a gown. If there is a clinical need for an item of clothing to be adjusted, obtain informed consent from the patient.	
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 are we proposing to change?	The requirement to obtain consent for both removal or adjustment of clothing has been imported from E6 (2016). There are minor linguistic changes.	
Why are we proposing this change?	The change reduces duplication within the Code.	

E4	Consider the need for (or advisability of) another person to be present to act as a chaperone or advocate for 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. Record when you offer or use a chaperone or advocate.	
Code 2016:	**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.*
What are we proposing to change?	"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.	
Why are we proposing this change?	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.	

Principle F
Obtain appropriate, informed consent from patients

Code 2016:	*Principle E:* *Obtain informed consent for all aspects of patient care*
What are we proposing to change?	"All aspects of patient care" has been removed.
Why are we proposing this change?	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 informed consent from the patient, or other valid authority, for clinical, and some non-clinical procedures.

Code 2016:	
What are we proposing to change?	The introduction to Principle F sets out how it represents core shared values: Honesty, Integrity and Transparency; Patient-Centred Care; Safety and Quality; Professionalism.
See also:	• GCC Guidance: Consent - https://www.gcc-uk.org/assets/publications/GCC_Consent_guidance_(July_2022).pdf

F1	Give the patient 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. 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 are we proposing to change?	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 are we proposing this change?	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:	• Standard F2 - Give due regard to the patient's capacity to give informed consent, considering that their capacity can change over time. • Standard A4 - Support the patient with their care, health and wellbeing. Involve them in decisions about their care. • 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 patient's capacity to give informed 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 are we proposing to change?	Capacity has been amended to focus more broadly on the capacity to consent, rather than the narrower capacity to understand.	
Why are we proposing this change?	This updates the Code, in line with the GCC Guidance on Consent (2022)	
See also:	• Standard F1 - Give the patient accurate, relevant and clear information in a format that is accessible to them… • News story on GCC Guidance: Consent - https://www.gcc-uk.org/gcc-news/news/entry/new-guidance-on-consent-published	

F3	Obtain, and record, informed consent from a patient (or their valid authority) before: • commencing assessment or care, • involving them in teaching or research, • making a recording of them, • disclosing identifiable information about them (unless there is another legal 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 are we proposing to change?	"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 when disclosing identifiable information about them.	

Why are we proposing this change?	There are gaps in the 2016 Code whereby it does not address situations where a patient does not have capacity to consent, or 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 a lasting power of attorney (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.

F4	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 are we proposing to change?	Minor linguistic change only	

F5	Take additional care to obtain informed consent when seeing a child or vulnerable patient, 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 are we proposing to change?	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 are we proposing this change?	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
Communicate professionally, properly, and effectively

Code 2016:	*Principle F:* *Communicate properly and effectively with your patients, colleagues and other healthcare professionals*
What are we proposing to change?	We have added the requirement to communicate “professionally”. We have removed “with your patients, colleagues and other healthcare professionals”.
Why are we proposing this change?	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, 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 forms of media.

Code 2016:	
What are we proposing to change?	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 are we proposing to change?	“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 are we proposing this change?	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. 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. 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 are we proposing to change?	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 are we proposing this change?	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 2016 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.	
See also:	• Standard D7 - Inform the patient of the risks, benefits and alternatives to the proposed plan of care…	

G3	Have visible and easy to understand information for the patient on • fees • charging policies • complaints These policies must include the patient's right to change their mind (remove consent) about their care and their right to refer any unresolved complaints to the GCC. You must respond quickly to any complaints that arise. If you practise in Wales, you should consider also making your policies 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 are we proposing to change?	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 are we proposing this change?	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; sharing information with the consent of the patient.	
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 are we proposing to change?	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".	
Why are we proposing this change?	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. This amendment updates the Code in line with our Education Standards.	

G5	Provide information to the patient about everyone who provides their care, distinguishing between colleagues who you have delegated care to, those who you have referred the patient to, and those (such as yourself) who are responsible for their regular care. Include arrangements for when you are unavailable.	
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 are we proposing to change?	We have added the requirement to distinguish between whether you have delegated care, or referred the patient to colleagues.	
Why are we proposing this change?	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.	

G6	Use the internet (include media sharing, social networking sites and user generated content) responsibly, maintaining professional boundaries and checking that information is not misleading or in conflict with your duty to promote public health and maintain public confidence in the profession.
Code 2016:	*New Standard*
What are we proposing to change?	This new standard introduces requirements for the way in which you communicate and interact with patients and the wider public through digital media.
Why are we proposing this change?	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.
See also:	• Standard C5 - Ensure the credibility of any health information that you share, demonstrating transparency, and accountability: information must be evidence-based, and accessible to its intended audience. • GCC Guidance: Social media and messaging - https://www.gcc-uk.org/assets/downloads/GCC_Social_Media_and_Messaging_Guidance_18_October_2021_(Final).pdf

Principle H
Foster collaborative healthcare, effective professional relationships and safe, supportive workplace practice

Code 2016:	*New Principle*
What are we proposing to change?	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 and G6).
Why are we proposing this change?	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 2016 Code

Introduction to Principle H:

It is essential that chiropractors work well with others, within the workplace, externally and inter-professionally, in the interest of keeping patients **safe** and ensuring the **quality** of their care. This includes maintaining respectful **professional** relationships and a positive workplace culture, as well as an active duty to act upon the poor behaviour of others. Chiropractors are also required to give **professional** support to others, where appropriate

Code 2016:	
What are we proposing to change?	The introduction to Principle H sets out how it represents core shared values: Safety and Quality; Patient-Centred Care, Professionalism.
Why are we proposing this change?	Our 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 includes: • Collaborating effectively in the best interests of patients • Delegation of care • Teamworking • Leadership • Interpersonal relationships • workplace culture (bullying/harassment) • training, mentoring etc The new Principle will address requirements of the varied and widening range of environments within which chiropractors work. This will ensure both effective direct care of patients and also effective wider service delivery, for the benefit of patients.

H1	Enhance the integrated care of the patient by collaborating effectively with other health and care professionals.
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 are we proposing to change?	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 are we proposing this change?	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 2016 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. Ensure that the person you delegate to is qualified, competent, supervised and supported.
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 are we proposing to change?	Requirements around delegation have been moved from the current Principle G (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 delegate.
Why are we proposing this change?	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	Foster effective team working and professional interpersonal relationships. When required, support the design, delivery, evaluation, and enhancement of healthcare services, and the integration of patient care within these services.
Code 2016:	*New Standard*
What are we proposing to change?	We have added new requirements addressing teamworking and professional interpersonal relationships. The standard also sets out the need for engagement with the healthcare service in which one works, as required according to the chiropractor's role and setting.
Why are we proposing this change?	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 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 in your role as an autonomous healthcare professional.
Code 2016:	*New Standard*
What are we proposing to change?	There is a new requirement for the leadership role that every chiropractor has.
Why are we proposing this change?	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 • GCC Toolkit: Enhancing patient care through leadership - https://www.gcc-uk.org/assets/downloads/GCC_Toolkit_Leadership_FINAL.pdf

H5	Treat others in the workplace fairly and with respect. Take action if you become aware of bullying, harassment, or intimidation of patients, colleagues or others; by following relevant procedures and keeping everyone involved safe.
Code 2016:	*New Standard*
What are we proposing to change?	There are new requirements around workplace behaviours.
Why are we proposing this change?	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	When the performance or conduct of colleagues puts others at risk of harm; report, follow up and escalate concerns by following relevant procedures. Act quickly and appropriately when concerns are raised to you; and encourage and support colleagues to raise their concerns.
Code 2016:	*New Standard*
What are we proposing to change?	There are new requirements around reporting concerns and responding to reports of concerns that colleagues are putting others at risk of harm.
Why are we proposing this change?	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 whistle blow, 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.
See also:	• Principle B2 - When you have concerns about the safety of a patient, act promptly and appropriately, and record what you did. • Principle C12 - Raise concerns about colleagues if you believe they are treating people unfairly, have discriminated against someone or if their personal biases have detrimentally impacted the care they provide. Raise concerns following the relevant procedures and maintaining the safety of everyone involved.

H7	Be prepared to contribute to mentoring, teaching, training and professional development of students and other colleagues. Allow your workplace colleagues to meet their regulatory duties.
Code 2016:	*New Standard*
What are we proposing to change?	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.
Why are we proposing this change?	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
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 are we proposing to change?	Current Principle G has now become Principle I, but is otherwise unchanged.

Introduction to Principle I:

Chiropractic practice is a career-long journey that requires the ongoing development and maintenance of skills and knowledge to keep up to date with developments affecting **professional** practice. Chiropractors work within their scope of practice. They continuously monitor their need to adapt and update their practice, taking responsibility for remaining up to date, and for further developing and improving their **professional** performance.

Code 2016:	
What are we proposing to change?	The introduction to Principle I sets out how it represents core shared values: Safety and Quality; Professionalism.

I1	Continuously enhance the care and safety of patients through reflective practice. Seek feedback and analyse information about your practice and the care you provide.
Code 2016:	*New Standard*
What are we proposing to change?	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 are we proposing this change?	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 are we proposing to change?	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 are we proposing this change?	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. Integrate findings of the best quality evidence into your practice, to enhance the care of patients.
Code 2016:	*New Standard*
What are we proposing to change?	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 are we proposing this change?	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 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 continuing professional development activities. 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 are we proposing to change?	“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 are we proposing this change?	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. 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 are we proposing to change?	G3 (2016) and G4 (2016) have been merged. Minor additional re-wording amendment	
Why are we proposing this change?	Merging the standards reduces duplication.	

I6	Recognise the roles and expertise of other chiropractors and healthcare professionals. 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 are we proposing to change?	There is an expanded requirement to recognise where the expertise of other chiropractors or healthcare professionals may lie, with respect to your own.
Why are we proposing this change?	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	Do not allow another person 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** *Do 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 are we proposing to change?	“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 are we proposing this change?	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
Maintain and protect information about patients

Code 2016:	*Principle H:* *Maintain and protect information about patients*
What are we proposing to change?	Current Principle H has now become Principle J, but is otherwise unchanged.

Introduction to Principle J:

Patients have the right for their personal information to be protected. Chiropractors fulfil their duty to ensure the proper confidentiality of patient information by storing patient records responsibly, by keeping up to date with advancing technology and taking positive action to prevent improper disclosure of patient information.

Code 2016:	
What are we proposing to change?	The introduction to Principle J sets out how it represents core shared values: Safety and Quality; Professionalism.
Why are we proposing this change?	Professionalism is a core shared value between patients and chiropractors. Properly maintaining and protecting the personal information of patients is a professional duty of chiropractors. Technology and the challenges that is opens up has developed further since the publication of the 2016 Code, necessitating some amendments to bring it up to date.

J1	Keep information about patients confidential and avoid improper disclosure of their personal information, through any medium. The responsibility for security is yours, and you cannot delegate accountability to third-party suppliers responsible for the day-to-day management of data. 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 are we proposing to change?	There is clarification that improper disclosure of personal information relates to "any medium". There is a new statement setting out that where third-party suppliers are used for day-to-day management of data, responsibility and accountability remain with the chiropractor. There is a new requirement to adapt to advancing technology, including data sharing, media sharing and social media, to proactively protect the patient's personal information.
Why are we proposing this change?	Our stakeholders told us that the existing Code did not explicitly enough address the use of newer, rapidly developing technologies. The addition to H1 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:	• GCC Guidance: Social media and messaging - https://www.gcc-uk.org/assets/downloads/GCC_Social_Media_and_Messaging_Guidance_18_October_2021_(Final).pdf

J2	Only disclose personal information without the consent of the patient in accordance with the law. Record the disclosure and the legal basis.	
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*
	H2	*only disclose personal information without patient consent if required to do so by law.*
What are we proposing to change?	E7 (2016) and H2 (2016) have been combined. Disclosure of patient information to third parties is also covered by F3, and by other relevant regulators (and therefore C3). The requirement has changed from only disclosing personal information "if required to do so by law", to "in accordance with the law".	
Why are we proposing this change?	The proposed amendment more accurately captures the legalities of disclosing personal information. In addition to being legally required to disclose information, there may be circumstances when it is permitted to do so, i.e. where there is an exception to the general rule of confidentiality. This is more consistent with the GCC Guidance: Confidentiality (2018).	
See also:	• GCC Guidance: Confidentiality (2018) - https://www.gcc-uk.org/assets/publications/GCC_Guidance_Confidentiality_(2018)_(Rebranded_Oct_2021).pdf	

J3	Keep patient records up to date, legible, and attributable. Your record must be representative of your interaction with each patient. Retrospective amendments or additions to patient records must be clearly identified.	
Code 2016:	**H3**	*ensure your patient records are kept up to date, legible, attributable and truly representative of your interaction with each patient.*
What are we proposing to change?	There is an additional requirement to clearly identify retrospective changes to patient records.	
Why are we proposing this change?	The amendment clarifies requirements around retrospectively amending records.	

J4	Store patient records safely, and securely (whether physically or digitally) so that they remain in good condition for the retention period described in law (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 are we proposing to change?	There is additional specification setting out that the requirement for safe secure storage applies whether storage is physical or digital.	
Why are we proposing this change?	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.	

J5	Have 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 are we proposing to change?	We have specified that “proper arrangements” refers to protecting or transferring patient records.	
Why are we proposing this change?	The amendment clarifies that this standard is about patient records. This is not specified in the 2016 Code.	

J6	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 are we proposing to change?	“Make sure” has been changed to “ensure”.	
Why are we proposing this change?	The minor linguistic change is more consistent with the formal language of the Code, conveying the requirement for a proactive approach to be taken.	

J7	Give patients access to their personal health records as required by law.	
Code 2016:	**H7**	*give patients access to their personal health records as required by law.*
What are we proposing to change?	Unchanged from H7 (2016)	

Mapping The Code of Professional Practice to the Code (2016)

This publication maps the standards and principles in The Code of Professional Practice to the principles and standards within The Code 2016 and has been produced for the purpose of the 2024 consultation.

It is not the final document and may be subject to change following the conclusion of the consultation period.

Your Feedback is Vital – Act Now!
Share your insights on the Code of Professional Practice

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