General Dental Council

Revisions to Guidance for the Interim Orders Committee and supporting documents

Consultation outcome report

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Published December 2023

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Introduction

The GDC is committed to improving its fitness to practise processes wherever possible, and one way we intend to meet that objective is through a comprehensive review and improvement of our guidance for decision makers at each stage of the fitness to practise process.

As part of that work, we undertook a review of the Interim Orders Committee (IOC) Guidance, the IOC Conditions Bank and the Glossary of Terms which relates to the guidance at each stage of the fitness to practise process.

When a fitness to practise concern about a dental professional is raised, depending on the nature of the allegations and the associated assessment of risk to public safety or confidence in the dental professions, it may be necessary for the registrant's practice to be restricted while the investigation is underway. In these instances, a referral to the IOC will be made.

Given the level of restriction on professional practice an interim order can impose, we believe it was appropriate to consult on proposed changes being made to the Guidance which supports decision making at the IOC.

The 12-week consultation on proposed changes to the IOC Guidance opened on 10 November 2022, and closed on 2 February 2023.

Proposed changes to IOC guidance

Drawing on the results of research, internal GDC audits and developments in case law, we proposed updates to:

- support the consistent and appropriate assessment of immediate risk by the IOC (Q3)
- support the assessment of risk posed by allegations of serious misconduct (Q5)
- support decision making by the IOC which is proportionate to the risks posed (Q7)
- improve transparency and understanding in how the IOC works, particularly in relation to more procedural issues (Q9)
- provide comprehensive guidance to IOC panel members (Q11)
- improve understanding, through an updated Glossary of Terms (Q13)

In addition, the consultation sought feedback and views on our Equality Impact Assessment of the proposed updates to the Guidance (Q14). The final question (Q15) invited respondents to make any further comments on the proposed updates.

Summary of consultation responses

The consultation was hosted on the GDC website and responses were submitted through Jisc Online Surveys. We received a total of 69 responses, 68 of which were received via that Jisc platform. One response was received by email.

Responses were received from 13 organisations, one of which submitted two responses. These were:

British Association of Dental Nurses (BADN)
British Association of Private Dentistry (BAPD)
British Dental Association (BDA) & BDA Indemnity
British Society of Dental Hygiene and Therapy (BSDHT)
Denplan part of Simplyhealth
Dental Defence Union (DDU)
Dental Laboratories Association (DLA)
Dental Protection Limited
Dental Technologists Association (DTA)
Magnavision Ltd.
MDDUS
RightPath4 Ltd.
Society of British Dental Nurses (SBDN)

55 of the responses received were from individuals. Of those, four indicated they were members of the public and/or a patient, and 51 indicated they were registered dental professionals.

Of those indicating they were registered dental professionals, 46 were dentists (with two of those indicating they were on one or more specialist list), three were dental nurses, one was a dental care professional registered with multiple titles, and one was a dental technician.

Our approach to the analysis and consideration of consultation design

The consultation was set out in pairs of questions from Q2 – Q13, with the first question of each pair asking a closed question about a specific, focused issue, with 'yes', 'no', or 'don't know' as the possible responses to the question. The second question of each pair sought further information on the same specific focused issue, as an open question with a free text space to leave the desired response.

Responses to the closed questions leaned either heavily or slightly towards 'no' answers, with the exception of question 12 which asked whether the updated Glossary of Terms improved understanding of the terminology used and the fitness to practise process, which leaned slightly towards a 'yes' response.

However, on average over the six pairs of questions, only 8.3% of those who responded 'no' to the closed question went on to provide a relevant substantive answer to the paired open question.

While not all responses to the open questions addressed the specific question being posed, many responses were relevant to broader aspects of the IOC Guidance, and these instances were considered in the sections of this report that most closely relate to the points being made or, where no obvious fit was apparent, in the analysis of responses to Q15 which invited more general comments.

We publish the closed question data in the relevant sections below and follow each table with commentary on the feedback that addressed the specific, focused issue. Within this commentary we detail the significant number of changes of note that we have made as a result of feedback received. Where appropriate, we have also provided commentary on the reasons for why we have decided not to make changes in response to feedback received.

Thinking about the disconnect between the closed and open questions in each pair which we describe above, we will consider how we design future consultation exercises to make sure we give people the opportunity to tell us what they think while also ensuring we get the feedback we need.

Analysis of consultation responses

Supporting consistency in the assessment of immediate risk – Q2 and Q3

Our consultation proposed:

We want to improve consistency in our approach to assessing immediate risk by the Interim Orders Committee (IOC).

We are proposing updates to the IOC Guidance that give further information on the factors that should be considered when assessing immediate risk to public safety and confidence in the following areas:

- Clinical cases (paragraphs 67-68).
- Alleged lack of indemnity insurance (paragraphs 69-71).
- Failure to cooperate with an inquiry (paragraph 72-74).
- Alleged sexual misconduct, harassment, and violence (paragraphs 75-79).
- Working beyond of scope of practice (paragraphs 80-82).
- Concerns about the health of a dental professional (paragraph 83).[1]

Question 2: Are the descriptions of the factors that should be considered by the IOC under each of the allegation types listed above, clear and comprehensive enough to support the IOC to make consistent and appropriate judgements on immediate risk to public safety and confidence?

Table 1: Q2 all responses

Response	No. of responses	%[2]
Yes	15	22
No	44	64
Don't know	8	12
No response	2	3
Total	**69**	

Table 2: Q2 responses from individuals

Response	No. of responses	%
Yes	11	20
No	37	67
Don't know	6	11
No response	1	2
Total	**55**	

1 These paragraph references have been updated to reflect the location of the relevant sections in the final updated Guidance. For reference, in the version of the Guidance we consulted on, these sections were located at paragraphs 64-65, 68, 69-71, 72-76, 77-79 and 80.

2 Percentages in tables do not always total 100 due to rounding.

Table 3: Q2 responses from organisations

Response	No. of responses	%
Yes	4	29
No	7	50
Don't know	2	14
No response	1	7
Total	**14**	

Question 3: Do you have any views on how we can further improve the IOC Guidance to support consistent and appropriate assessments of risk by the IOC?

GDC response

Clinical cases (paragraphs 67–68)

One response asserted that the section on clinical cases (paragraph 67–68) was too broad and, as a result, was open to mismanagement. As such the respondent asked for more information on the level of clinical allegation that would give rise to an immediate interim order.

In addition to the examples of the type of clinical cases which may cross the threshold for IOC consideration provided at paragraph 67, paragraphs 63 and 64 establish a proportionate safeguard:

- that the IOC must be satisfied 'that an order is necessary for the protection of the public'
- and in making that assessment, the IOC will 'consider the seriousness of the matter, the cogency and weight of the evidence, including evidence about the likelihood of repetition should the registrant continue to hold unrestricted registration while the matter is investigated.'

For these reasons, we believe there is sufficient detail included in this section of the Guidance and, as such, have decided not to add further detail.

Non-cooperation (paragraphs 72–74)

We received a small number of responses which challenged the principle that non-cooperation with a fitness to practise investigation could or should lead to an interim order. This principle is not only established by the Standards for the Dental Team (we have strengthened the reference to the Standards in paragraph 72 of the Guidance, as a result of the feedback received), but it is also a long-established principle that members of regulated professions must engage and fully cooperate with their professional regulator, whose role it is to maintain standards and uphold public confidence in the professions.

We also note the following passage from the judgement in Saha v The General Medical Council (GMC)[3]: 'Whilst it may seem harsh to characterise a merely *[sic]* failure to respond to an information request from the GMC as conduct which calls into question a practitioner's very fitness to practise, on the other hand the GMC's regulatory role is central to the 'public interest' considerations of patient protection and public confidence. Paragraph 30 of Good Medical Practice [which requires full cooperation with a formal inquiry] enables the GMC to carry out that role effectively, and a practitioner's failure to comply with it is likely to obstruct the GMC in carrying out that task.'

3 Saha v The General Medical Council [2009] EWHC 1907 (Admin).

While the principle is not in question, paragraphs 63 and 64, provide a proportionate safeguard to its application. For these reasons we have not amended the section in the Guidance on non-cooperation.

One respondent suggested that paragraph 74 could reference mitigated risk if non-cooperation was caused by an evidenced health issue. We decided against making this change because the assessment to be made is one of current risk to public safety or confidence, and these are factors which are unaffected by what is causing the non-cooperation.

Conduct concerns including sexual misconduct, harassment, or violence (paragraphs 75 – 79)

Significant challenge was received in relation to the inclusion of the passage 'mainstream opinion is now that there is virtually zero tolerance of sexual misconduct'.

Some respondents felt there was too much ambiguity in the phrase 'mainstream opinion', while others felt that the phrasing indicated pre-judgment of the case. While this phrase was lifted directly from the judgement in Arunachalam v The GMC[4], we agree that the description of the principle established in that case is unhelpful for this Guidance. As such we have removed this phrasing.

Another response made the point that the IOC must be able to consider the strength of the evidence in each individual case for the imposition of an order, rather than operating a blanket approach. We agree, and consider that paragraphs 63 and 64, as noted above, provide a proportionate safeguard.

It was suggested that the word 'potential' needed to be added to paragraph 79 to read 'has the potential to seriously undermine public confidence'. We agree and have adopted this wording.

Several responses pointed out that the list of considerations for the IOC were couched in definitive language (i.e. 'the victim' or 'the incident' as opposed to 'the alleged victim' or 'the alleged incident'), which is inconsistent with the IOC's role being one of risk management rather than of fact-finding. We agree and have introduced consistent references to alleged actions, both in this section and in all other sections within 'Grounds for imposing an order'.

One response sought to challenge the inclusion of the consideration cited at paragraph 76 (iv), 'there was an alleged imbalance of power between the registrant and the alleged victim by reason of their respective professional positions, age, and/or physical stature'.

The challenge was on the grounds that:

- 'there could always be said to be a power imbalance vis a vis a dentist and a patient'
- 'shorter people may be just as capable of inappropriately exerting power as those who are taller.'

The principle cited at paragraphs 76 (iv) was established in Professional Standards Authority for Health and Social Care (PSA) v GMC & Anor[5], and as such we have retained the reference.

Finally, one response suggested that the inclusion of reference to 'risk to public confidence in the dental professions' in this section 'necessary for the protection of the public', rather than in the next section 'otherwise in the public interest', blurred the lines between the two limbs of the test. While we agree with this feedback to a certain extent, on balance, we felt there was value in exploring the various aspects relating to sexual misconduct together. As such, we have retained this reference at paragraph 79, but have also cross-referenced paragraph 88 to reflect this point.

4 Arunachalam v The General Medical Council [2018] EWHC 758 (Admin).

5 Professional Standards Authority for Health and Social Care v General Medical Council & Anor [2021] EWHC 588 (Admin).

Scope of practice (paragraphs 80-82)

We received a small number of responses which called for a clearer definition of 'working beyond the scope of practice'. In response, we have inserted specific references to the Standards for the Dental Team and Scope of Practice Guidance.'

Supporting the assessment of risk posed by allegations of serious misconduct – Q4 and Q5

Our consultation proposed:

Based on the findings from our research on how different healthcare regulators apply the concept of seriousness, we have updated the IOC Guidance to provide additional information on dealing with allegations considered to be particularly serious.

We have added alleged serious and/or persistent dishonesty to the list of allegations with the potential to damage public confidence in the dental professions (paragraph 88)[6]. And provided further information on cases involving:

- sexual misconduct, harassment, and violence (paragraphs 75-79)
- criminal proceedings (paragraphs 90-95).[7]

Question 4: Do these updates provide sufficient information to panellists on how to treat serious allegations of misconduct and how to effectively assess the immediate risk to public safety and confidence in the areas listed above?

Table 4: Q4 all responses

Response	No. of responses	%
Yes	25	36
No	31	45
Don't know	11	16
No response	2	3
Total	**69**	

Table 5: Q4 responses from individuals

Response	No. of responses	%
Yes	16	29
No	29	52
Don't know	9	16
No response	1	2
Total	**55**	

6 This paragraph reference has been updated to reflect the location of the relevant section in the final updated Guidance. For reference, in the version of the Guidance we consulted on, this section was located at paragraph 85.

7 These paragraph references have been updated to reflect the location of the relevant sections in the final updated Guidance. For reference, in the version of the Guidance we consulted on, these sections were located at paragraphs 72-76 and 87–91.

Table 6: Q4 responses from organisations

Response	No. of responses	%
Yes	9	65
No	2	14
Don't know	2	14
No response	1	7
Total	**14**	

Question 5: Do you have any views on how we can improve or better reflect the research evidence on seriousness in the IOC Guidance?

GDC response

The concept of 'public confidence'

One response pointed out that the research, The concept of seriousness in fitness to practise cases, highlighted that fitness to practise decision makers have varying understandings of, and ways of applying, the concept of public confidence. As such, they asserted, further research to into the concept, with a view to developing additional guidance around it, may be desirable.

While further insight into the concept of public confidence may be generally helpful, this poses a separate question to whether the Guidance provides sufficient direction, and our view is that the test established in paragraph 87 of the Guidance does provide sufficient direction to IOC on public confidence.

As part its work to review the threshold for meeting Standard 3 of the Standards of Good Regulation[8], the PSA introduced new guidance[9] in May 2023 which set out its updated approach to assessing the performance of regulators against the Standard. A new evidence matrix[10] accompanies the guidance and, while the PSA recognised there is little in practice in the matrix which most regulators were not already doing (or planning to do), it was designed to further support regulators in meeting the Standard. Considering the new guidance and matrix, we recognised we could improve how allegations of racist and other discriminatory behaviour are addressed in the IOC guidance, one of the Outcome 3 indicators in the matrix. As such, we have updated paragraph 88 to explicitly include 'discriminatory behaviour on the grounds of any protected characteristic' in the list of concerns that have the potential to damage public confidence in the dental professions.

Criminal proceedings (paragraphs 90 – 95)

One response challenged the principle set out in paragraph 90 that 'the IOC should consider… whether, in the event that the registrant is later convicted, it will damage public confidence that they have been able to continue working unrestricted in the meantime', arguing that 'the IOC should only be concerned with the information before [it] at the time and make its considerations accordingly.'

8 Standard 3 of the PSA's Standards of Good Regulation: The regulator understands the diversity of its registrants and their patients and service users and of others who interact with the regulator and ensures that its processes do not impose inappropriate barriers or otherwise disadvantage people with protected characteristics.

9 Guidance for regulators: assessing performance against Standard 3 (May 2023).

10 Performance review Standard 3 evidence matrix (May 2023).

Certain criminal allegations do carry an inherent current risk. While that risk relates to a potential future event, the risk is current, and should therefore, legitimately be considered for mitigation through an interim order. For this reason, this section of the Guidance remains unchanged.

With reference to the principle outlined at paragraph 93, another respondent called for us to make clear that the principle in question - that where a practitioner has been convicted of a serious criminal offence, they should not be permitted to resume practice until satisfactorily completing their sentence - was a general principle and was not to be universally applied (i.e. it should not be applied in circumstances which plainly justify a different course of action). We agree, and have amended paragraph 93 to reflect this position.

Ensuring decisions are proportionate to the risk posed – Q6 and Q7

Our consultation proposed:

We want to ensure that the judgements and decisions made by the IOC are proportionate and appropriate to the risks posed to public safety and confidence.

To help achieve this goal we have expanded the section on proportionality (paragraphs 103 -110)[11] in the IOC Guidance, alongside the changes we set out at Question 2 of this survey in reference to the assessment of immediate risk.

Question 6: Do these updates provide sufficient information to panellists on how to ensure decisions are proportionate to the risk posed and that any restrictions imposed on a dental professional's practice are proportionate to the issues identified?

Table 7: Q6 all responses

Response	No. of responses	%
Yes	16	23
No	40	58
Don't know	10	15
No response	3	4
Total	**69**	

Table 8: Q6 responses from individuals

Response	No. of responses	%
Yes	8	15
No	37	67
Don't know	8	15
No response	2	4
Total	**55**	

11 These paragraph references have been updated to reflect the location of the relevant sections in the final updated Guidance. For reference, in the version of the Guidance we consulted on, these sections were located at paragraphs 98-105.

Table 9: Q6 responses from organisations

Response	No. of responses	%
Yes	8	57
No	3	21
Don't know	2	14
No response	1	7
Total	**14**	

Question 7: Do you have any views on how we can further improve the IOC Guidance to ensure that decisions are proportionate and appropriate to the risks posed?

GDC response

Several respondents noted that a passage which had appeared in the October 2016 version of the Guidance, which required the IOC to 'balance the need to protect the public and the wider public interest against the registrant's own interests, including the impact of any order on the registrant both professionally and financially', had been removed. Those respondents called for that requirement to be restored. We agree, and have updated paragraph 104 to reflect this.

Several respondents felt that the threshold for proportionality had been ill-defined. Paragraph 103 introduces the section by setting the threshold for an interim order as being necessary for the protection of the public, otherwise in the public interest, or in the interests of the registrant concerned. Our view is that this, alongside the rest of the section, but particularly the updated paragraph 104 referenced above, effectively sets out the proportionality threshold.

With reference to paragraph 106, one respondent queried what was meant by 'the registrant's capacity to comply' with conditions, and whether this related to a. 'an assessment that the registrant would not cooperate with conditions, or b. that the registrant 'cannot practically comply' with the conditions. This phrase is intended to cover both scenarios, and we have updated paragraph 106 to clarify.

One respondent argued that seriousness should be one of the factors taken into account by the IOC when deciding what, if any, interim order was required. We agree, and have updated paragraph 110 to reflect this.

In relation to paragraph 111 and the period of the order, one respondent highlighted that the wording implied that 'less than 18 months duration will be the exception rather than the norm', which was a contrary principle set out in case law cited (Harry v GMC12). We agree, and have updated the paragraph to make clear that 18 months is not the default position, and that questions of proportionality also arise in respect of the term of the order.

12 Harry v GMC [2012] EWHC 2762 (Admin).

Improving transparency of rules, considerations and decision making – Q8 and Q9

Our consultation proposed:

We want to improve transparency of interim order rules, considerations and decision making by the IOC. We have updated the IOC Guidance and the IOC Conditions Bank to delivery these improvements. The IOC will refer to the IOC Conditions Bank and the risk being posed, when taking decisions on restricting the practice of a dental professional.

We have updated the IOC Guidance to provide further details on what should be considered when assessing immediate risk to public safety and confidence (as set out at Question 2). We have also added information on procedural matters that were not previously covered, but that may arise in the context of an IOC hearing. Updates have been made to the following sections:

- postponements and adjournments (paragraphs 12-29)
- joint hearings (paragraphs 30-33)
- registrants with existing restriction on registration (paragraphs 34-49)
- mode of hearing (paragraphs 53-54)
- the approach to testimonial evidence (paragraphs 99-102).[13]

We have made presentational changes to the IOC Conditions Bank to provide further clarity and, where appropriate, timescales to relevant conditions on practice, as follows:

- Standard conditions (section 1, rows 1-4).
- Conditions involving, supervision, reporting, submitting logs, and the use of a chaperone (throughout).

Question 8: Do the additions to the IOC Guidance on considerations for the assessment of immediate risk and procedural matters, and the clarifications to the IOC Conditions Bank on timescales, supervision and reporting provide sufficient transparency for users?

Table 10: Q8 all responses

Response	No. of responses	%
Yes	16	23
No	38	55
Don't know	12	17
No response	3	4
Total	**69**	

13 These paragraph references have been updated to reflect the location of the relevant sections in the final updated Guidance. For reference, in the version of the Guidance we consulted on, these sections were located at paragraphs 9-26, 27-30, 31-46, 50-51 and 95-97.

Table 11: Q8 responses from individuals

Response	No. of responses	%
Yes	9	16
No	33	60
Don't know	11	20
No response	2	4
Total	**55**	

Table 12: Q8 responses from organisations

Response	No. of responses	%
Yes	7	50
No	5	36
Don't know	1	7
No response	1	7
Total	**14**	

Question 9: Do you have any views on how we can provide further transparency in interim order rules, considerations and decision making through updates to the IOC Guidance or IOC Conditions Bank?

GDC response

Postponements and adjournments (paragraphs 12 – 29)

In the October 2016 version of the Guidance, there was no reference to postponements and the approach to adjournments is addressed in a single paragraph in limited detail.

The changes are designed to support the IOC in making proportionate and consistent decisions, which observe relevant legal precedent, in relation to postponements and adjournments.

A central principle, well-established by legal precedent, is that any culture of adjournment is to be discouraged, recognising that, while the discretion on whether to grant a delay must be exercised fairly and should take account of all relevant factors, the efficient and expeditious running of fitness to practise hearings is of significant public interest14. Given the urgent nature of IOCs, this public interest is even more significant.

Given the increased focus on these issues in the Guidance, this section attracted significant feedback and challenge. Some criticised the tone of the section and others challenged the perceived increase in prescription, pointing out that the decision was one for the IOC alone to take.

While the updated Guidance makes it clear that discretion lies with the IOC, and that it must be exercised fairly (paragraphs 16, 21 and 22 (iii)), we recognise that the Guidance would benefit from this principle being repeated in other sections. As such, in addition to the references at paragraphs 16, 21, and 22 (iii), the principle is also now referenced at paragraphs 24 and 29.

14 General Medical Council v Adeogba [2016] EWCA Civ 162.

Significant challenge was raised in relation to postponements and adjournments on the grounds of ill health (paragraphs 25 and 26). Respondents argued that the requirements, as set out in the version consulted on, set the bar too high and that this was exacerbated by the short time frames involved at IOC. Of particular concern was the requirement for 'independent' medical evidence, based on 'a proper examination by a relevant medical professional'.

We agreed with these challenges, and have updated the section accordingly. We have also deleted certain passages of this section relating to expert medical evidence, given the limited application to the IOC.

Significant challenge was raised in relation to postponements and adjournments on the grounds of seeking legal representation (paragraphs 27-29). Respondents particularly objected to the phrase 'A registrant does not have an unfettered right to legal representation'; a principle highlighted in Hussain v General Pharmaceutical Council[15].

Hussain confirms that, whilst it is vital is that registrants have the right to a fair trial, a fair trial is not necessarily dependent on having legal representation. At paragraph 28, the Guidance states that the IOC must have regard to the six considerations set out at paragraphs 22-24. This underlines that every hearing will turn on its own facts, and that a registrant will not be denied a postponement or adjournment on the grounds of seeking legal representation where it would be unfair to do so.

On this basis, this principle remains in the Guidance. However, we recognise this section should have first set out the right to a fair hearing, which includes legal representation where appropriate, before going on to explain why the right to representation is not an unfettered one, and we have updated the section to reflect this.

Joint hearings (paragraphs 30 – 33)

Some respondents challenged the new section on Joint IOC hearings. There was some concern that the Guidance did not ensure registrants' interests would be sufficiently considered as part of the decision to hold a joint hearing.

We agree, and have inserted an explicit reference to the requirement to consider fairness to the registrant in paragraph 33.

Registrants with existing restrictions on registration

Several respondents challenged the notion of parallel interim orders, which is detailed at paragraph 44 (ii). The challenges are driven by the erroneous interpretation that this is something that can or should be appropriately avoided through case management timing. This is not a matter of timing, particularly when concerns are entirely separate. As such, we have decided not to make changes to this section.

The approach to testimonial evidence (paragraphs 99 – 102 and paragraph 24 (iii))

The October 2016 version of the Guidance is silent as to the weight that should be attached to testimonial evidence. However, it is addressed twice in the version of the Guidance issued for consultation, at both:

- paragraph 24 (iii) in relation to whether applications for postponement or adjournment should be accepted/rejected
- paragraphs 99–102 in relation to the weight that should be attributed to testimonial evidence more generally in the IOC process.

15 Hussain v General Pharmaceutical Council [2016] EWHC 656 (admin).

These paragraphs draw on the principle established in Kumar v GMC[16], that testimonial evidence carries limited weight. The principle is set out briefly in paragraph 100 of the Guidance:

> '… the IOC is conducting a risk assessment. The fact that a registrant has on many occasions been a competent practitioner and has made a good impression on colleagues and patients, is not inconsistent with the same registrant having performed below a level of competence on other occasions, and is not determinative of the question of current risk to the public.'

Some respondents questioned the wording, asserting that the language was inappropriately leading, and that the weight of testimonial evidence should be a judgement left entirely to the IOC.

In our judgement, the language used is appropriate to describe the principle established by Kumar, and as such we have retained the wording in these sections.

We also consider that the Guidance could have been clearer in making the point that the principle applies equally to cases involving allegations of personal behaviour. As such, we have expanded this section to make this clear.

Conditions Bank

We received feedback that the requirement in Condition 2 was unclear. Condition 2 reads: '… you must inform the GDC… of any… patient complaint received about your clinical practice or conduct at work.'

The guidance for Condition 2 provides the following explanation:

> 'The condition also ensures the GDC can monitor any new patient complaints received about the dental professional's work or conduct at work. The GDC can use this to check if these are similar in nature to those that led to the initial IO and consider whether the IO in place still manages the risks identified appropriately, or whether it may need to be varied.'

Our view is the wording of Condition 2, and the associated guidance, is clear.

It was also suggested that the requirement was changed either to require only complaints about the same/similar issue(s) or for this function to be fulfilled by a workplace reporter.

In our view, relying on the judgement of the registrant to identify patient complaints that are similar in nature would not provide a sufficiently robust approach. Further, a workplace reporter may not be required by the conditions in all cases, and in our view, it would be disproportionate to require the appointment of a workplace reporter in all cases simply to satisfy this Condition. As such, we have decided to not make any changes to Condition 2.

In relation to Condition 7 (and other conditions with the same requirement), some respondents felt that the requirement for the workplace supervisor to provide a report 14 days in advance of a review hearing was excessive. We disagree. The requirement is in place to ensure the GDC and its legal team has adequate time to review the report ahead of the review hearing. As such, this requirement has been retained.

We received feedback that the wording of Conditions 26-32 implied that only a single chaperone would be permitted, and that this may cause practical difficulties. We agree, and have amended these conditions to make it clear that multiple chaperones can be nominated and approved.

16 Kumar v General Medical Council [2013] EWHC 452 (Admin).

Respondents felt that some aspects of Conditions 26-32 may have a disproportionate impact:

- Condition 27 - respondents felt that it would be sufficient for the registrant to share with their chaperone(s) their conditions rather than the full determination. We agree, and have updated this condition accordingly.
- Condition 32 - requires registrants to provide reports from their chaperone(s) every [X] months and at least 14 days prior to any review hearing. Respondents argued that this was disproportionate because chaperones (as registered dental professionals) had a general duty under the Standards for the Dental Team, to raise concerns through appropriate channels, including to the GDC. We disagree. This requirement is in place to manage a more specific, identified risk, which is to be mitigated proactively rather than by a general duty, and as such we have retained the proposed wording of the condition.

We received comments about Condition 47, which required sanctioned registrants to make arrangements, and pay for, alcohol or drug testing where the interim order required regular submissions of test results.

The feedback received raised questions of practicality, such as the suitability or approval of testing providers. We agree and have amended the conditions accordingly.

Ensuring panellists have comprehensive guidance – Q10 and Q11

Our consultation proposed:

We want to provide comprehensive IOC Guidance to panellists and stakeholders.

We have made extensive updates to the IOC Guidance and IOC Conditions Bank based on case law, audit findings and research evidence.

Question 10: Do the updates made to the IOC Guidance and IOC Conditions Bank reflect the latest evidence and provide for a comprehensive guide to the interim orders process for panellists and stakeholders?

Table 13: Q10 all responses

Response	No. of responses	%
Yes	13	19
No	37	54
Don't know	17	25
No response	2	3
Total	**69**	

Table 14: Q10 responses from individuals

Response	No. of responses	%
Yes	7	13
No	34	62
Don't know	13	24
No response	1	2
Total	**55**	

Table 15: Q10 responses from organisations

Response	No. of responses	%
Yes	6	43
No	3	21
Don't know	4	29
No response	1	7
Total	**14**	

Question 11: Do you have any views on how the IOC Guidance or the IOC Conditions Bank could be improved, made more comprehensive, or better reflect the evidence?

GDC response

Conditions Bank

In relation to the Conditions Bank in general, we received several responses which, in light of the greater level of detail provided, called for clarity that the IOC can depart from the conditions listed, where it sees fit.

The stated aim of the Guidance, and by extension the Conditions Bank, is to 'promote consistency of approach, transparency and proportionality in decision making by the IOC, when it is considering a matter referred to it' (paragraph 4 of the Guidance). It follows that the consistent construction of conditions, wherever possible, supports that aim.

However, paragraph 4 of the Guidance, goes on to state that the Guidance 'does not seek to fetter the IOC's discretion, or to impose a tariff.' This clearly establishes that it remains within the IOC's discretion to depart from the conditions set out in the Conditions Bank where it sees fit.

The introduction of the Conditions Bank states that the IOC should 'think carefully about how conditions are constructed to ensure they are targeted and manage any risks that have been identified while enabling the registrant to continue to practise', and should 'ensure any conditions set are workable, enforceable, will protect the public, and maintain public confidence in the dental professions.' This passage, which is echoed by paragraph 108 of the Guidance, underlines the discretion available to the IOC.

In relation to Condition 15, which requires the registrant not to work at any practice they own, respondents asserted that would effectively amount to a suspension. We disagree. As is set out in the guidance for Condition 13, the restriction is to help mitigate risks associated with conflicts of interest, fraud, or other similar issues. Condition 13 would not prevent a registrant from working, for example, as an associate dentist in another practice. In relevant circumstances, this condition would provide a workable alternative to a suspension and, therefore, achieve the objective of being proportionate and applying the least restrictive interim order possible.

With reference to Condition 47, which requires attendance at support group meetings at set periods of regularity to mitigate risks associated with alcohol and/or drugs misuse, it was suggested that it should simply state 'must attend regularly'. It was felt that this would prevent unavoidable breaches of the condition when, for example, a meeting was cancelled.

Our view is that the suggested alternate wording would undermine the robustness of the intended risk-mitigation. However, we agree that such scenarios should not lead to the condition being breached. For this reason, we have adapted Condition 47 to read: 'You must attend [monthly/bi- monthly] meetings of [specify support group], save where outside your control (e.g. a meeting is cancelled), if recommended to do so by your [medical supervisor/general medical practitioner/psychiatrist].'

Supporting improved understanding of the process and terminology – Q12 and Q13

Our consultation proposed:

We have updated the Glossary of Terms to support improved understanding of the interim orders and the wider fitness to practise process, from the making of allegations to the completion of sanctions.

Question 12: Do the updates on the Glossary of Terms support improved understanding of the terminology used and the fitness to practise process?

Table 16: Q12 all responses

Response	No. of responses	%
Yes	29	42
No	24	35
Don't know	12	17
No response	4	6
Total	**69**	

Table 16: Q12 responses from individuals

Response	No. of responses	%
Yes	19	35
No	22	40
Don't know	11	20
No response	3	6
Total	**55**	

Table 16: Q12 – responses from organisations

Response	No. of responses	%
Yes	10	71
No	2	15
Don't know	1	7
No response	1	7
Total	**14**	

Question 13: Do you have any views on how the Glossary of Terms could be improved to support improved understanding of the fitness to practise process or the terminology used?

GDC response

We received some feedback that the use of the word 'reviewer', in relation to clinical audits and case-based discussion, was unclear as to whom it was referring. We disagree. The word 'reviewer' in these instances is simply the person undertaking the said activity. We are reluctant to further define this role as it could be fulfilled by the Workplace Supervisor or the Workplace Reporter. As such, we have not amended these entries.

One respondent pointed out an inconsistency between the Conditions Bank and the Glossary of Terms in relation to chaperones. We have updated the Glossary of Terms to reflect the correct description of who can be a chaperone.

Further, it was pointed out that the description of chaperone focused on them being present whenever the registrant interacts with certain groups of patients, and did not reference colleagues or staff. We agree that staff/colleagues should be included in the definition. We have updated the Glossary of Terms, and made appropriate updates to the Conditions Bank.

With reference to logs, some respondents felt that the definition required logs to include more information than was always necessary, and could be disproportionate. We agree, and have updated the entry to provide clarity about the information that will always be required, and the additional requirements in clinical cases.

One respondent called for 'consistency of terms in all GDC guidance and literature of personal development plan, professional development plan and personal professional development plan.' We agree that consistency of terminology is important when talking about the same subject matter. However, the Personal Professional Development Plan (PPDP) referred to in the Glossary of Terms is not the same document as the Personal Development Plan (PDP) referred to our guidance on CPD requirements for dental professionals.

While the PDP gives dental professionals 'the opportunity to think about what CPD will give [them] maximum benefit for maintaining and developing [their] practice as a dental professional17, dental professionals are not required to use the PDP template. The PPDP, however, is designed to support dental professional to carefully assess how they will demonstrate the steps they have taken to address the undertakings identified by case examiners, or conditions imposed by a practice committee, or an IOC. The PPDP template provided must be used.

Impacts on equality, diversity and inclusion – Q14

Our consultation proposed:

We work to ensure that our regulatory activity is fair, transparent and accessible to all. Fulfilling our commitment to equality, diversity and inclusion means understanding where our processes and policies may impose inappropriate barriers, and taking action to remove them.

Our initial assessment of the potential impacts of the changes we are proposing can be found in the draft Equality Impact Assessment.

Question 14: Please review and provide any comments you may have on the draft Equalities Impact Assessment, particularly the likely impact of our proposals, positive or negative, on different groups of people.

GDC response

One respondent stated that we should have included menopause as a distinct protected characteristic in the Equality Impact Assessment. While we understand the argument for doing so, our established approach toward equality impact assessments is to assess against the protected groups identified in the Equality Act 2010. It is worth noting, however, that the Equality Impact Assessment did take account of Sex which is a protected characteristic identified in the Act.

We received feedback that we 'missed out gender critical as being a protected characteristic', with the respondent refencing Forstater v Centre for Global Development Europe18. This case established that gender-critical views are capable of being protected as a belief under the Equality Act 2010. As such, holding gender critical belief is not a separate protected characteristic in the Equality Act 2010. 'Religion or belief' was, however, included in the Equality Impact Assessment.

One response challenged our assessment that women would be positively impacted by our Guidance updates relating to sexual misconduct. The response read: 'I welcome women being able to feel safer within dentistry, but I'm not sure they need to be singled out. Everyone should feel safe within dentistry. Men may just as equally be targeted by a predatory woman or man, in the same way that a woman could be.'

17 Enhanced CPD guidance for professionals, section 5.1.

18 Forstater v CGD Europe & Ors [2021] UKEAT 0105/20/JOJ.

The entry in the Equality Impact Assessment read: 'Further guidance on considerations and weighting of sexual misconduct, harassment and violence. Potential for positive impacts over the long term for women (although not exclusively) if the policy acts as a further deterrent.'

The victims of sexual misconduct are disproportionately women. As such, we believe it was appropriate to recognise the anticipated positive impact of the updated Guidance in this way.

Any final views – Q15

Question 15: Are there any other comments you would like to make on the proposed IOC Guidance or IOC Conditions Bank that are not covered by your answers to the questions above?

GDC response

Several respondents reflected on the impact that fitness to practise processes in general, not necessarily in relation to the IOC specifically, can have on registrants.

Our overarching objective is the protection of the public, and investigating the concerns we receive about the practice, conduct, or health of dental professionals is one of the ways we pursue this objective.

However, we know that fitness to practise investigations can be stressful, particularly for the dental professional at the centre of proceedings. Only a very small percentage of all fitness to practise concerns raised result in suspension or erasure from the register but, understandably, the prospect of that looms large in the minds of those whose practice is being scrutinised.

Much of the fitness to practise process is dictated by outdated and rigid legislation, and only regulatory reform will bring the kind of wholesale changes needed to significantly improve the experience of those who are subject to investigation. In the absence of that reform, we continue to seek ways to improve our processes wherever we can.

Several respondents shared the view that interim orders are fundamentally incompatible with the principle that innocence is presumed until guilt is proven. We disagree.

The purpose of the IOC is not to reach any findings of fact but to assess whether there are risks which need to be managed while investigations are conducted. In doing so, it must balance the need to maintain public safety and confidence in the dental professions with the rights of the registrant concerned.

When considering whether an interim order is necessary, there are safeguards in place to ensure decisions are proportionate. Some of these safeguards are described in paragraphs 63 and 64 of the Guidance.

'63. The IOC must be satisfied on all the available information before it that an order is necessary for the protection of the public. That is to say that there is a real risk of harm to the health, safety or wellbeing of a patient, visitor, colleague or other member of the public if the registrant is allowed to practise without restriction.

'64. In assessing the risk to members of the public, the IOC will consider the seriousness of the matter, the cogency and weight of the evidence, including evidence about the likelihood of repetition should the registrant continue to hold unrestricted registration while the matter is investigated.'

A small number of respondents raised questions about the consistency of decision making in the process of referral to the IOC. It is of course important that the process leading up to the referral of a case to the IOC is fair and consistent, but that falls outside the scope of this guidance and so is not addressed further here.

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