

**General  
Dental  
Council**

## **GDC consultation response**

**Department of Health and Social Care  
consultation: Regulating anaesthesia associates  
and physician associates**

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# **GDC response to DHSC consultation: Regulating anaesthesia associates and physician associates**

## **1. Introduction**

- 1.1. For some years the General Dental Council (GDC) has called for reform to unlock the prescriptive and restrictive legislation under which we operate (the Dentists Act 1984), as it continues to limit our ability to respond to changes in dental practice, to operate an efficient, effective and proportionate regulatory system and, most importantly, to ensure public protection. We are in urgent need of an updated legal framework which provides sufficient flexibility to ensure effective regulation today, with the resilience to adapt to the inevitable changes in dentistry over years to come.
- 1.2. We therefore welcome this consultation and the Government's ambition for flexibility within the draft order for medical associates, which will subsequently provide the legislative blueprint for the reform of all regulators. Nonetheless, whilst we support much of the policy intention behind the draft order, we have strong concerns that in multiple areas, its translation into legislation does not actually achieve the intended effect. Our responses to the consultation questions follow in section 4; however, in this introduction we first highlight several broader points in relation to the overall approach to reform and its impacts.

### **Absence of a timetable for GDC reform**

- 1.3. Progress on reform has been slow, though its need is increasingly urgent. The Government first consulted upon the scope of reform in 2017, following the recommendations of a 2014 Law Commission review. In 2021, a second Government consultation 'Regulating healthcare professionals, protecting the public' set out more detailed policy proposals for a modernised and consistent regulatory framework for the reform of healthcare professional regulators.
- 1.4. While the publication of these proposals is an important milestone, they are disappointing in their lack of sustained ambition. The Government has chosen to prioritise the General Medical Council, the Nursing and Midwifery Council and the Health and Care Professions Council and we recognise its reasons for doing so. But the consequence is that there is not even an indicative timetable for the reform of GDC legislation, with the inevitable result that the widely recognised weaknesses of the current system are set to continue for the indefinite future.
- 1.5. This further delay has implications in two main areas. Firstly, the challenges associated with regulating effectively under the rigidity of our extant legislation are sustained. Of particular concern are those affecting our ability to keep pace with, and address, risks to public safety arising from the rapidly evolving dental landscape – for instance, technological advancements in care delivery. We are committed to making what regulatory improvements are possible within our legal constraints whilst we await reform (for example, improvements to our international registration processes and fitness to practice performance where possible) but we are undoubtedly limited in the scope and extent of what we can achieve, and this has consequences for patients, our registrants and our wider stakeholders.

- 1.6. The lack of clarity around the timing of a GDC order significantly affects our capacity to plan as an organisation. These uncertainties continue to hinder ongoing efforts to ensure that resources are used in a responsible way that limits opportunity costs and reduces the risk of abortive expenditure. This is exemplified in planning scenarios where, for example: projects are contingent upon reform outcomes; or preparatory work for reform needs to be timed appropriately to ensure that it is developed in the right context; or we have to choose whether to dedicate resource to improving our existing processes in the limited ways we can, or instead to making arrangements towards our readiness for reform.
- 1.7. For all these reasons, we emphasise the need to make the fastest possible progress towards legislative reform and urge the Government to prioritise reform for the GDC. We would very much welcome discussions with DHSC to specify a GDC timetable and a workable pathway for implementation of the required preparatory work for reform.

### **Implications of a template order approach**

- 1.8. We understand that the legislative order to bring medical associates into regulation under the GMC is intended to provide a template for the subsequent reform of all other healthcare professional regulators, including the GDC. However, we warn that a template approach to reform which does not recognise the differences, as well as the similarities, between the regulators and regulated professions will result in less effective regulation. It is essential that consistency of approach across regulators does not lead to the elimination of distinctive features of dental regulation which contribute to public protection and patient safety.
- 1.9. As already reflected in our response to the Government's 2021 consultation 'Regulating healthcare professionals, protecting the public', we recognise that for differently regulated professions working in the same teams or environment, consistency of the approach to regulation is important for members of the public and professionals. But that principle needs to be applied pragmatically. There are important differences between the professions and the environments in which they operate that must be reflected in different regulatory approaches. The GDC regulates the entire dental team, so in the overwhelmingly majority of clinical care settings for dentistry, there is already a common and consistent approach to professional regulation. With that consistency already in place for the sector, we think the real opportunity of reform for dentistry is to consider the powers required to effectively and flexibly regulate a diverse range of services and providers, working under different business configurations, that push at the boundaries of the current model of regulation and public protection.
- 1.10. Although we appreciate DHSC has recognised changes to the template would be necessary for each regulator, we are concerned that the areas of commonality between all regulators, and subsequently the standardised elements of the template, should not be overestimated. The first legislative order in the reform process will be for medical associates, and so principally addresses policy issues faced by the GMC. However, the GDC and other regulators face different sets of policy issues – for example, more complex registers, different practising environments, different protected functions and other regulator-specific issues – which may require extensive amendments to such a template. It will be important not to underestimate the potential scale of this requirement in planning the next stages of reform.

- 1.11. This also has implications for the statutory consultations required on the draft order for each regulator. If they are going to meet the Gunning principles, each consultation must be genuine and the responses to it must be taken into account when finalising the proposals. That cannot be achieved with an overly-rigid approach to the template. It seems inevitable – and right – that variation between the regulators will be introduced at that stage, even if it has not been before, since each of the regulators will have a different regulatory context driving their requirements.
- 1.12. Moreover, delays between this consultation and those for subsequent regulators may lead to even greater cause for variation. This is because certain issues may not have been addressed effectively as a result of this consultation, there would be changes in the wider regulatory environment to consider, and regulators' views may change with time.
- 1.13. Next year it will be forty years since the Dentists Act 1984 was enacted, itself a consolidation of legislation going back to 1957, and it has taken well over a decade of activity to reach this point in the reform programme. We are pleased that the Government agrees that this is a rare and significant opportunity to deliver reform and we are acutely aware that it may be many years before there is another opportunity to reconsider the overall regulatory approach. Therefore, it is crucial for the GDC to end up with a framework that is fit for purpose, and futureproofed, in the unique dental context. This is in the interests of patients and our registrants.
- 1.14. It is essential that the development process for a future GDC order recognises the need to make appropriate changes to the template legislation. In line with our Corporate Strategy 2023-25, we are committed to working with DHSC to achieve this and maximise the potential of reform for the GDC.
- 1.15. When GDC-specific proposals are brought forward, we will assess them on their merits at the time. We cannot fetter the discretion of a future Council to make their own judgement in the light of prevailing circumstances.

### **General issues with the quality and accessibility of legislative drafting**

- 1.16. It is essential that the reformed legislation for all regulators is drafted in a way which can be clearly followed and understood, so that the application of the law translates consistently into appropriate processes and outcomes for regulators, registrants and the public.
- 1.17. However, the template order is confusingly organised and much of the drafting is exceptionally ambiguous and unnecessarily convoluted. For example, the material does not always follow a logical order and there is a large degree of cross-referencing required throughout. In some parts, attempts to simplify and condense legislation have resulted in a lack of clarity around how the same powers might apply to multiple functions; in others, certain powers are not explicit on the face of the order and it appears that one must combine unrelated powers from separate parts of the order to create the desired policy effect, though it is unclear if this is the correct or intended method of application.
- 1.18. These accessibility issues pose risks around mixed interpretation and inconsistent application of reformed legislation in future, which in fact counters one of the key potential benefits of reform – to enable consistent regulatory outcomes across

healthcare professional regulation. This also significantly increases the future risk of legal challenge to regulators.

- 1.19. We strongly recommend that the drafting is reviewed and tested for optimum clarity, especially if the order is intended to be a template for repeated use for all regulators. As part of testing, we consider the drafting should meet a standard akin to that set by section 1.1 of the [Office of the Parliamentary Counsel Drafting Guidance \(2020\)](#). Amongst other important things, this includes that legislation should be set out in a logical order, so that later propositions build upon earlier ones, and that cross-references should be minimised.

## **2. About the GDC**

- 2.1. The GDC works on behalf of the public to regulate the dental team across the UK, maintaining a framework of standards to support the delivery of high-quality care. An individual must be registered with the GDC to practise dentistry in the UK.
- 2.2. The dental team is made up of diverse roles, each playing a different part in the provision of a wide range of different dental services with different risk profiles, in a multitude of settings, and to varying degrees of autonomy. The dental team includes dentists, dental nurses, dental hygienists, dental therapists, orthodontic therapists, dental technicians and clinical dental technicians.
- 2.3. Our overarching purpose when exercising our functions is the protection of the public, which involves the pursuit of the following objectives to:
  - protect, promote and maintain the health, safety and well-being of the public
  - promote and maintain public confidence in the dental professions
  - promote and maintain proper professional standards and conduct for members of those professions.
- 2.4. Our role in meeting these objectives is to regulate around 115,000 members of the dental team, which involves carrying out some specified mandatory functions. These are to:
  - set standards for dental education
  - maintain a register of qualified dentists and dental care professionals (DCPs) who meet the registration requirements
  - set and promote professional standards
  - investigate allegations of impaired fitness to practise.

## **3. How we have responded to the consultation questions**

- 3.1. Responses to the consultation questions are provided in section 4, using the section headings from the consultation document. Where questions have been posed in relation to the GMC and medical associates, we have treated these as referring to the GDC and dental professionals respectively. We have signalled where the answers to certain questions are also applicable to others.
- 3.2. The responses address the main areas of risk as they would impact the GDC should the same approach for the draft legislation be taken for a future GDC order, whilst also highlighting some of the key areas where differences in dental regulation would require

us to diverge from the template framework. We acknowledge that DHSC will be considering the GDC's specific set of bespoke powers and how these are translated into reforms separately to the development of the common regulatory framework.

- 3.3. Though we agree with much of the policy ambition behind the draft order, support many of the flexibilities which have been introduced, and recognise the potential for significant improvements across our regulatory functions, we have considerable concerns about the draft legislation in a range of areas. As reflected in our responses, some of these concerns relate to particular policy approaches; others relate to issues around whether the effects of the legislation actually deliver the suggested policy intent; and others relate to wider drafting issues, as referred to in sections 1.16-1.19.
- 3.4. We note that the general lack of clarity in the drafting has in several places hindered our ability to recommend changes for the proposals.
- 3.5. We would be happy to provide DHSC with further detail if that would be helpful in developing drafting.

## 4. Response to consultation questions

### Part 1: General

#### **(Q1) Do you have any comments relating to 'part 1: general' of the consultation?**

Our comments are in relation to the interpretation of terms.

##### *A) "Approved qualification"*

As used in the draft order, "approved qualification" includes overseas qualifications which the regulator has accepted as one part of its assessment of whether an overseas qualified registrant meets its standards of education and training for registration. Whilst we understand that, under proposals, the different processes for approval of UK training and the recognition of international training could be set out in rules, the choice to use the same language for international and UK qualifications may lead to confusion about the differences between these processes. Further, this language conflicts with that used in the Professional Qualifications Act 2022 and the Dentists, Dental Care Professionals, Nurses, Nursing Associates and Midwives (International Registrations) Order 2023 - which both refer to the recognition of, as opposed to the approval of, overseas qualifications. It is vital that the risk of inconsistent interpretation of language does not result in process, policy or legal challenges.

##### *B) "Person"*

"Person" has not been defined in the order; however, use of the word "person(s)" throughout the draft is not necessarily clear or consistent in meaning. In some cases, our reading is that it should be taken by its ordinary meaning, in others, that it should incorporate both persons and organisations. We seek clarity due to the risk of misinterpretation.

##### *C) "Registrar" and "Regulator"*

In some areas of the drafting, it is unclear why a power has, or has not, been allocated to the "Registrar" or "Regulator". It is therefore unclear what the intention is regarding how the power should be carried out. We would recommend consistent allocation of powers to the appropriate roles throughout.

## Part 2: Standards and approvals

**(Q2) Do you agree or disagree that the powers outlined in ‘part 2: standards and approvals’ are sufficient to enable the GMC to fulfil its role safely and effectively in relation to the education and training of AAs and PAs? Please explain your answer. NOTE: This question does not relate to the GMC’s powers for setting the standards for registration contained in Part 3.**

We disagree.

Broadly speaking, we welcome the proposals in Part 2 as they would provide enhanced powers which would enable us to play a more direct role in approval and quality assurance of dental education and training at all career stages across the seven dental professions for the purpose of public protection. However, we raise concerns and seek clarity in several areas below.

### *A) Absence of power for suspension of approval*

Under Article 4 ‘Approvals’ there is no power for the suspension of approval. We consider that such a power should be included in the draft order, with an effect distinct from withdrawal of approval in respect of the speed with which it applies (withdrawal decisions would be delayed due to the provider’s right to make representations, meaning a prolonged period where any presenting risks remain) and the effect of decisions to lift suspension potentially being quicker than that of decisions to reinstate approval.

Suspension would be beneficial over withdrawal in certain cases. For example, learning from our pandemic experience demonstrated that in extreme and unforeseen circumstances there may be pressures placed on dental education which restrict the opportunity for students and trainees to acquire the full breadth of experience required for safe and effective practice. In those rare circumstances there may need to be an accelerated route to suspend approval for education and training until shortfalls can be addressed. This would provide a clearer route for students to be able to apply for registration once a suspension is lifted.

### *B) Approvals in relation to “things anywhere”*

At Article 4(2), the regulator may make any of the education and training approvals at Article 4(1)(a) in relation to “a person or thing anywhere”. Whilst we understand the policy intent is to allow approvals for international education and training, we are unsure of what is meant by “things”, and quite how far the meaning of this word could be taken to reach - especially in international contexts – which opens us up to challenge. We cannot assume that “things” cover only the items included at Article 4(1)(a) (i.e. education, training, providers, qualifications, examinations, assessments) unless this is specified in the drafting.

### *C) Right to representations, revisions and appeals*

There are proportionality issues around the right to representations, revisions and appeals.

More generally, the same right to representations, revisions and appeals exists for international, as well as UK, approvals. This could be particularly difficult to manage given that any provider (or potentially other bodies – see our comments in section B above) anywhere could come forward to request approval.



We also have concerns associated specifically with decisions to attach conditions on approval and decisions to withdraw approval. We understand that in the draft order for those particular decisions:

- Under Article 13(1)(a), the applicant must be given the opportunity to make representations before a decision is made under Article 4(1)(b).
- Under Article 11(1)(a), once a decision has been made, it may be revised; and under 13(1)(b), a revision would similarly carry a right to make representations.
- Under Article 12, the decision can be appealed.

Whilst we recognise that the initial right to make representations may in fact reduce the risk of subsequent revisions and appeals, the overall route set out is unnecessarily onerous for the education and training context, especially given the number of hearing opportunities to be exhausted ahead of an appeal stage. Additionally in this context, many decisions are time sensitive (for example, in relation to a cohort of students in their graduating year), which may cause additional risks if the effects of certain decisions are delayed by this process (for example, if as a result, cohorts of students are unable to graduate).

In our existing education quality assurance processes, providers have the opportunity to make factual corrections and provide observations on a report, prior to a particular regulatory outcome; this provides an opportunity to address matters that may otherwise reach an appeal stage. This part of our processes has a similar effect to making representations, though we recognise that in the draft, representations may be made about anything and may be written or verbal. Whilst we could potentially adapt our processes to meet enhanced legislative requirements, we question how this would add benefit. It is also unclear in the drafting by whom representations should be considered and whether this can be constrained by conditions set out in rules.

In relation to decisions for the attachment of conditions, we consider that appeals should be isolated to the final outcome of the education quality assurance process. At the point a condition is attached, approval has not yet been decided.

The comments in this section are also relevant in answer to questions 17, 18 and 21.

#### *D) Co-ordination of stages of training and education*

Under the provision at Article 4(3), the regulator may co-ordinate the stages of education and training of professionals. However, we seek clarity as to the meaning of “co-ordinate”, and whether this provision could actually deliver something distinct from, or in addition to, the effects of powers around standards and approvals at Articles 4(1) and 4(2).

Roles within the current dental education and training sector are multiple and varied, and we consider the future roles the GDC could play should be focussed on only those with a clear link to public protection. Though policy development work and consultation with our stakeholders would be required to inform any changes to our role, the areas in which the GDC may have an interest in education and training (for example: training leading to a registrable qualification; post-registration training, including foundation training schemes, specialty dentist training, non-specialty related training for additional skills, and Continuing Professional Development) appear to be covered by Articles 4(1) and 4(2). There is also potential through other powers in the order to attach conditions to registration in a system akin to provisional registration (though we flag issues with powers around conditions in our response to Q8), which could be used in conjunction with approval powers - for example, overlaying foundation training schemes with provisional registration - to allow ‘co-ordination’ of sorts.

**(Q3) Do you have any additional comments on ‘part 2: standards and approvals’ in relation to the drafting approach as it would apply to all regulated healthcare professionals?**

The work to adapt complex arrangements for dentist specialty training to new powers for education will need to be accounted for in transitional arrangements for the GDC. In specialty training arrangements, there is added complexity relating to the retention of EU training requirements for two of the GDC’s thirteen specialties, namely orthodontics and oral surgery. We will need to consider the effect of proposals on the European Primary and Specialist Dental Qualifications Regulations 1998 and any interaction with the end of the EU Exit stand-still period.

For dentists’ education, there are some components of our existing regulatory model which provide elements of public protection that will need to be considered carefully if the GDC’s role in approvals changes under reform. For example, the wider consequences of removing ‘dental authority’ status from dental schools would need to be assessed and allowed for.

**Part 3: The register**

**(Q4) Do you agree or disagree that the draft Order provides the GMC with the necessary powers to determine the standards and procedural requirements for registration? Please explain your answer.**

We disagree, for the reasons set out below.

*A) Standards for registration*

The draft order has the effect that the regulator must set standards for education, training, knowledge, skills, experience, conduct, performance, ethics, and English language, and assess whether professionals meet those standards for registration purposes. A series of issues stems from this approach and the grouping of these standards.

- The set of registration standards at Article 6(2)(c)(i) appears to conflate education and training standards, registration requirements, and professional standards, which are all relevant to different functions. It would be much more useful to differentiate the functions that the standards need to provide (for example: for quality of education and training; for application to the register; for maintenance of registration).

This conflation leads to proportionality issues for all functions to which the registration standards pertain. For example, at initial registration it is odd to have standards for knowledge, skills and experience in addition to standards for education and training when this is arguably duplicative – we consider that knowledge, skills and experience are a result of the applicant’s training. In the case of restoration applications under Articles 6(1)(a) or 6(1)(b), the applicant would have to satisfy all of the same standards at Article 6(2)(c)(i), but in some circumstances it may not be necessary to assess all of them (e.g. if a professional’s registration and associated clinical activity had only lapsed for a very short time period, it may not be necessary to reassess their knowledge, skills and experience). It is also unclear whether for restorations, education and training standards could be covered by Continuing Professional Development (CPD) evidence, or whether another type of evidence would be needed if CPD standards were considered to fall into a different grouping of standards at Article 3(1)(b). As explained in our comments at Q25 Part A, there are further issues around evaluating the registration standards for the ongoing assurance of registrants.

- It is unclear how an assessment of performance, conduct and ethics – which has not been a direct part of the model of regulation previously – could be conducted in a robust way. For instance, this may require longitudinal behavioural assessment, or many varied pieces of evidence. It is also unclear as to whether other checks or declarations could serve as proxy measures for this assessment. For instance, our existing good character checks may satisfactorily cover an assessment for conduct or ethics.
- An assessment of ‘ethics’ is particularly problematic. While the GDC has a role in promoting ethical behaviour as part of professionalism, and communicates ethical principles via its standards and guidance, we consider that ethics (given their ordinary definition) are not something we can assess, nor have a remit to assess, at registration. The term ‘ethics’ is not used in the GDC’s extant legal framework and in this context, it is unclear what ‘ethics’ adds beyond ‘conduct’.
- We have very strong concerns for international applicants, who are at high risk of being disadvantaged by an approach which includes a mandatory assessment of performance, conduct and ethics. Differences in international jurisdictions (for example, variation in codes of conduct or ethics) may mean that they are less likely to have the requisite evidence – even if under our existing model we would consider them safe to join the register and expect them to uphold professional standards around performance, conduct and ethics once registered.

Against all of the above, we would recommend that an approach is taken whereby standards are expressed in terms of, or linked specifically to, the functions they provide (this would include performance and conduct being linked to standards for the maintenance of registration), and that reference to ethics or ethical standards is removed and potentially replaced with ‘professional standards’ or similar.

We emphasise the need for clarity for registration standards so that applicants and regulators have a clear basis for providing and reviewing evidence as part of an application, no groups of candidates are unfairly disadvantaged, there are no unnecessary burdens placed on regulators – and ultimately, patient safety is not compromised.

For information, we note that the GDC’s current assessment is centred around knowledge and skills for registration, then further checks for health, good character, indemnity and English language.

#### *D) Absence of ultimate discretion for Registrar to grant registration*

In the draft order, there is no discretionary power for the Registrar to turn down an applicant for registration. We would recommend its inclusion at Article 6(2), so that even where specified registration criteria are met, the Registrar may still refuse registration in the interest of public protection

We envisage that such a power would be used only exceptionally because regulators’ criteria for registration should be comprehensive for the vast majority of cases. Nonetheless, allowing the Registrar ultimate discretion would provide an additional means to take action to protect the public in extraordinary circumstances which may be challenging to account for in our rules and guidance. For example, where there is concern that an awarding body of an approved qualification has compromised its standards and the Registrar concludes that patient safety would be at risk if registration were granted.

The power could be safeguarded by ensuring that its use is monitored and reported on for transparency, and that an applicant has a right to appeal a decision of the Registrar made against them.

*E) International registration*

The proposed legislation makes no explicit mention of routes for international registration, as there has been no delineation of UK and international processes throughout the drafting. Although we recognise the proposed mechanisms through which we could set separate processes for the recognition of qualifications and assessment against the standards for registration for international applicants, it is essential that everything provided for under the recent amendments to the GDC's extant international registration legislation (Dentists, Dental Care Professionals, Nurses, Nursing Associates and Midwives (International Registrations) Order 2023) is similarly provided for under a future GDC order.

We note additional relevant comments at Q1 part A, Q2 part B and Q4 part A.

For a long time, the GDC has been under considerable pressure to improve its international registration processes, which until March this year were heavily restricted by legislation. Now that changes to our legislation have come into effect, we are making every effort to develop our policy and processes for the benefit of international candidates; this translates into significant resource commitment, with work long underway, much more to be undertaken, and benefits to be realised over a period of years. In future it is critically important that legislative barriers are not put in the way of this work by the planned reform.

**(Q5) Do you agree or disagree that the draft Order provides the GMC with proportionate powers for restoring AAs and PAs to the register where they have previously been removed due to a final measure? Please explain your answer.**

We disagree.

There is no clarity around the regulator's ability to assure that fitness to practise is not impaired when applicants have previously been removed through voluntary or administrative erasure, and we recommend this is explicitly referred to in the order.

We also recommend an explicit power to refuse restoration applications for those who have previously been removed for a listed offence as set out in Schedule 2, because these are offences which are fundamentally incompatible with registration with a healthcare regulator.

See additional comments at Q4 Part A regarding issues around the standards at Article 6(2)(c)(i) in the context of restoration.

**(Q6) Do you agree or disagree that the draft Order provides the GMC with proportionate powers for restoring AAs and PAs to the register where the regulator identifies in rules that it is necessary for the applicant to satisfy the regulator that their fitness to practise is not impaired? Please explain your answer.**

We disagree.

At Article 6(1)(b), we consider it should be the Registrar, as opposed to a 'person', who is satisfied by restoration requirements.

We are concerned that the two-step restoration process described is disproportionate and may create unnecessary process steps in certain circumstances. For example, in a case where someone has been removed due to non-payment of a registration renewal fee, then applies to re-join the register after a very short time lapse, it would be disproportionate to require a fresh assessment of the entire set of registration requirements at Article 6(2) when the case could be appropriately dealt with administratively.

The proportionality issues already described in Q4 Part A, relating to the standards for registration at Article 6(2)(c)(i) in the restoration context, are also relevant.

We interpret Article 6(1)(b)(ii) as meaning that the requirement to demonstrate that fitness to practise is not impaired would apply only to situations the regulator sets out in rules, and not to every case - but we warn of confusion around the reading here.

**(Q7) Do you agree or disagree that the powers in the draft order relating to the content of the register and its publication will enable the GMC to effectively maintain a register of AAs and PAs who meet the standards to practise in the UK? Please explain your answer.**

We disagree for the reasons below.

*A) Structure of the register*

With regards to Article 5(1)(a)(i) and the proposal for the regulator to keep a single register, the GDC currently maintains two registers – one for dentists, the other for dental care professionals (DCPs) - which are presented as a single public facing register. We have no objection to keeping a single register in principle; however, to merge our two existing registers would result in a significant burden of work to an end which makes no material difference to how the public access the register and confers no advantage to public protection. We consider that it would be as effective for us to maintain our two registers as a single public facing register.

We note in relation to Article 5(2), that the GDC DCP register is sub-divided by six specific DCP titles. The dentist register is not sub-divided but is associated with thirteen specialist lists. Additionally, a very small number of dentists on the register are listed as temporary registrants. These arrangements will need to be appropriately accounted for in any new register structures for the GDC. Specialist list arrangements add further complexity in that EU retained legislation requires us to keep separate lists for the two specialties of orthodontics and oral surgery. Therefore, we will also need to consider the effect of proposals on the European Primary and Specialist Dental Qualifications Regulations 1998 and any interaction with the end of the EU Exit stand-still period.

*B) Information recorded and published on the register*

These comments relate to Article 5(3) (duty to record information on the register) and Schedule 3 Paragraph 4 (duty to publish registration information) in the draft order.

The Registrar is required to record and publish information related to a professional's practice regarded as serving the purpose of public protection. However, whilst we recognise this set of information may differ between regulators depending on specific regulatory needs, there is a risk of mixed interpretation around what could reasonably fall under this classification of information. Clarity is sought around whether this information must only relate to enhancements or restrictions on a professional's practice, or whether it could cover broader but relevant things.

For example, the GDC currently publishes registrable qualifications on its register. In future we would consider that qualifications approved by the GDC could be classified as information related to professional practice which serves the purpose of public protection, as they support public confidence in the register by linking to the regulatory approval process. Additionally, in dentistry, qualification information on the register supports processes in NHS organisations responsible for access to performers lists. However, qualifications may not always be related to a defined change in a professional's scope of practice.

Similarly, the GDC publishes the specialty status of dentists on its register. Specialities in dentistry are not attached to a legally enhanced scope of practice, however their publication helps the public, professionals and employers identify dentists with recognised specialist training in a distinct branch of dentistry and supports appropriate patient referral.

As a separate point, given the nature and effect of (non-FtP) conditions on registration (Article 7) for certain registrant groups, we would expect a duty to publish such conditions to be made explicit.

**(Q8) Do you agree or disagree that the draft Order provides the GMC with the necessary and proportionate powers to reflect different categories of registration and any conditions that apply to the registration of people in those categories? Please explain your answer.**

We disagree. We are confused at the intent behind non-emergency 'conditional registration' and how this has been translated into legislation.

More generally, the policy commentary suggests that conditional registration would allow regulators to operate a system akin to provisional registration. However, the effects of the drafting appear to confuse the core concepts of provisional registration (in which registration ends by default at a particular point or via a distinct termination process) with a model for annotations to the register (in which underlying registration is maintained, but scope is potentially changed via annotation). Linked to this confusion:

- it is unclear whether or not conditions could be scope-enhancing, as well as scope-restricting
- there is no direct route to remove a registrant for non-compliance with conditions (see further comments at Q9 Part C).

A further issue is that the term 'conditions' is extremely unhelpful as is it almost guaranteed to be confused with FtP conditions which are individualised sanctions – and therefore entirely different things. We would suggest that the terminology is amended for clarity.

In principle, we agree with the introduction of legislative mechanisms which would allow us more flexibility to regulate the practice of defined groups of registrants, including through provisional registration type models. Such mechanisms could offer more opportunities for the safe transition of new and returning registrants – including international candidates – into practice, as well as to indicate enhanced scope where appropriate in the dental context. However, the provisions in the draft must be clarified to allow for this.

**(Q9) Do you agree or disagree that the draft Order provides the GMC with proportionate and necessary powers in relation to the removal of AA and PA entries from the register which will enable it to operate a safe and fair system of regulation that protects the public? Please explain your answer.**

We disagree, and seek clarity in the following areas.

#### *A) Incorrect or fraudulent entry*

In the draft order, removal of an incorrect or fraudulent entry from the register is discretionary. We firstly seek clarity as to whether information within an entry, as well as the entry in its entirety, may be removed. We consider both powers are necessary to appropriately manage erroneous or fraudulent information.

We also highlight a lack of clarity around how the discretion for the removal of fraudulent or incorrect entries should be exercised, particularly in the event that a suspension from practice is required whilst investigations into an alleged fraud or error are undertaken. There is no direct route for the Registrar to suspend the registrant or impose conditions, unless this is permissible through rule-making powers at Schedule 4 Paragraph 3(2)(a) – this is unclear. With regards to powers to investigate, it is not clear that the powers at Schedule 3 Paragraph 7(1)(b) (to evaluate fitness to practise impairment) could be used in these circumstances, especially as these cases may not always, or strictly, be considered under FtP.

Although under Article 7, the proposals would allow regulators to set conditions on groups of registrants in scenarios where fraud was suspected or they had been affected by third party fraud, the nature of scenarios may vary, and conditions are likely to need to be individualised for the particular circumstances.

#### *B) Non-compliance with CPD standards*

We seek clarification that we could remove an entry from the register for non-compliance with CPD requirements under the provision at Article 8(2)(b)(ii)(aa) where a registrant has not complied with the procedure for evaluating standards and/or under Article 8(2)(b)(ii)(ee) where a registrant has not provided information in accordance with a requirement in the order.

#### *C) Non-compliance with (non-FtP) conditions*

As also expressed in answer to Q8, proposals do not include an explicit route to remove registrants for non-compliance with (non-FtP) conditions, or a way for 'provisional registrants' (or registrants practising under a similar scheme) to be removed from the register by default at the end of a 'provisional registration' period. The only ways for such registrants to be removed appears to be through an FtP route or a route for non-compliance with the regulator's procedures for evaluating standards – neither of which align with the policy intent for provisional registration.

#### *D) Need for reserve power of administrative suspension*

In some exceptional cases - for example, whilst investigating a fraudulent entry to the register (see Q9 Part A) or where a registrant is the subject of a serious criminal investigation - we consider there is a need for the Registrar to have a reserve power for administrative suspension as an accelerated route to protect the public from potential risks which cannot necessarily be addressed quickly or effectively through FtP processes. We would recommend inclusion of such a power in the order.

**(Q10) Do you have any additional comments on 'Part 3: The register' in relation to the drafting approach as it would apply to all regulated healthcare professionals? Please explain your answer.**

The GDC has a form of registration for dentists only called 'temporary registration', covered by Section 17 of the Dentists Act. For clarity, this is not the same as 'temporary and occasional registration' which exists in the GMC model. Temporary registration provides a means for

overseas qualified dentists to undertake approved roles in specific supervised environments for a limited period without requiring full registration. This facet of our current regulatory model will need to be considered carefully as part of reformed register structures, and especially against the outcomes of proposals around conditional registration (see our response to Q8), as there may be potential for temporary registration to evolve into an improved scheme more similar to provisional registration under reforms.

As has already been discussed with DHSC, the GDC's current legal framework contains a set of bespoke business powers which will need to be considered for reform of the GDC and may require the template legislation to be varied.

**(Q11) Do you agree or disagree that the draft order provides the necessary powers to enable the GMC to implement an efficient and safe system of temporary registration for AA and PAs during a period of emergency as declared by the Secretary of State? Please explain your answer.**

We agree. However, we note that although we have no objection to the set of emergency registration powers proposed, we consider that emergency registration would have very limited utility in the dental context. For example, in our experience of the COVID-19 pandemic, dental service provision was initially reduced to urgent care only, with many dental professionals redeployed to support wider non-dental healthcare services. Whilst we received a small number of requests from former registrants to reactivate their registration, that was with the desire to provide pandemic care, rather than to practise dentistry. Therefore, the emergency did not lead to a workforce shortage which an emergency register could have addressed; nor would it seem appropriate to establish an emergency register when we do not anticipate those that join it to practise their registered profession.

#### **Part 4: Fitness to practise**

**(Q12) Do you agree or disagree that the powers in the draft order enable the GMC to implement a 3- stage fitness to practise process for AAs and PAs proportionately and sufficiently? Please explain your answer.**

We disagree.

We understand that DHSC's policy intention is for there to be a three stage Fitness to Practise (FtP) process (initial assessment, case examiner stage, and FtP panel stage), with the ability for regulators to write into rules the process for the initial assessment stage. We strongly support this policy intention; however, we emphasise equally strongly that the draft legislation will not deliver this intention due to a total absence of the initial assessment stage on the face of the order.

DHSC has indicated that the rule making powers under Schedule 4 Paragraph (3)(1)(a) for FtP procedures (in relation to Articles 9 and 10) confer rule making powers for the initial assessment stage on regulators. However, we do not agree. This is because Article 9 begins with the assertion that the case examiner (CE) may decide to dispose of the case where a question about fitness to practise arises, thereby starting from the second FtP stage, with no explicit reference to the first.

There are major implications for us if the initial assessment stage, and the associated rule making powers, are not made explicit in legislation. These include that there is no legislative basis for:



- Setting up a filtering mechanism to determine what amounts to a fitness to practise concern.
- Gathering evidence before CE stage (see further comments at Q25 Part B).
- Closing cases before CE decision.
- Referring a case to an interim measure before CE stage.
- Revising or appealing decisions made before CE stage.

Therefore, it is vital that the drafting be amended to make clear the initial assessment stage, with effects which include that:

- when a concern is raised, in the first instance the regulator decides whether to refer this to a case examiner to make a decision
- the regulator has the power to set out in rules the investigative procedure during initial assessment for concerns raised.

The GDC has long been affected by the legal restrictions on its existing FtP processes, which result in negative impacts on registrants, witnesses and informants. Much effort is being put towards FtP improvement work, though we are extremely limited in how much we can achieve absent of reform. It is essential that reform delivers the flexibility we require to develop more proportionate and responsive approaches to FtP, leading to better outcomes for professionals and the public. A key part of this must be to operate an initial assessment stage which aligns with our ambitions to reorientate FtP efforts towards the most serious cases, and close less serious cases as quickly as possible.

**(Q13) Do you agree or disagree that the powers in the draft order enable case examiners to carry out their roles appropriately and that the powers help to ensure the safe and effective regulation of AAs and PAs? Please explain your answer.**

We disagree for the following reasons.

*A) Case examiner decisions*

We support the proposal for CEs to have a wider range of outcomes available to them including accepted outcomes (agreement with the registrant), erasure and warnings. Under these proposals they can also apply an outcome, where they have found impairment but there has not been written agreement from the registrant. To support CEs in exercising these powers, cases would need to be front loaded so that evidence gathering is concluded at an early stage. Therefore, we refer to our responses at Q12 and Q25 Part B and the need for the first stage of the FtP process to be made explicit so that it can be written into regulators' rules.

*B) Grounds for impairment*

The draft order contains only two statutory grounds for impairment: inability to provide care to a sufficient standard; and misconduct.

The Dentists Act currently provides for grounds for impairment covering misconduct, deficient professional performance, health, criminal convictions and rulings from another regulatory body.

In the absence of guidance from DHSC as to the intention behind the two proposed grounds or guidance on how our current structure maps into these grounds, we see no benefit in reducing the grounds of impairment to the two proposed categories. We consider that such a move presents risks, particularly since existing case law relates to existing grounds, leaving regulators open to challenge on decisions when there is no judicial precedent.

There is a risk associated with 'inability to provide care to a sufficient standard' as a ground, as it appears to suggest that regulators would only consider harm once it has occurred, rather than additionally considering the potential for future harm, when a concern is raised. This could create a gap in patient safety standards.

The removal of health as a separate ground is particularly problematic. The existence of health as a distinctive ground for concern means that such cases can be taken forward in a way which can be more supportive and less stressful for affected registrants, in part because they are aware that there is a more limited range of potential sanctions. That means that it can be easier to create opportunities for remediation and to support registrants to remain in the profession. All of that in turn enhances patient protection, since there is an intervention route available which can pre-empt patient harm.

Depending on circumstances, we do not consider that health concerns would necessarily fit into either of the two proposed grounds. Our view is that cases involving the health of the registrant might require a different approach to other cases to address risks and support the registrant in the most appropriate ways, and that maintaining health as a separate ground more easily facilitates this. This would reduce the risk of registrants affected by poor health or disability being disadvantaged.

#### *C) Warnings and no impairment sanctions*

The lowest statutory outcome in the draft order is a warning. Often, in FtP cases, there are degrees of concern that do not meet the threshold for a warning but may still need some kind of regulatory outcome which acts as a flag should the regulator see the same issue again with the registrant. Currently the Dentists Act gives case examiners the power to issue advice, which is an outcome that we deem serves this purpose. We would seek to retain this outcome following regulatory reform.

#### *D) Case review*

It is unclear where the power for the case review process (i.e. the review of sanctions) sits within the draft order. This power is necessary to vary measures, for example, from condition to suspension, or suspension to erasure, or by altering conditions. It may be that the intention is that this power sits in Article 11 (revisions), however there are significant issues with that Article, as explained in our response to Q17, which also highlights the issues around case review in FtP. We recommended that the case review process is clearly articulated in the order.

**(Q14) Do you agree or disagree that the powers in the draft order enable panels to carry out their roles appropriately and that the powers help to ensure the safe and effective regulation of AAs and PAs? Please explain your answer.**

We disagree for the reasons below.

#### *A) Final Measures – terminology*

We suggest that the term 'Final Measures' may be misleading to the public as there are routes to revise that decision, such as appeals or applications for restoration. A term that indicates that this is an outcome at this stage of the process may be more appropriate.

## *B) Final Measure sanctions*

Under proposals, conditions or suspensions imposed as a Final Measure may be issued for a maximum of 12 months, after which the regulator may apply for an extension. Additionally, this extension may only be requested on the basis of a material change in circumstances.

We consider that these provisions overlook patient safety and legal considerations as set out below:

- It is often necessary to extend sanctions on the basis that there has been no change in circumstances. For example, this may occur in an alcohol or drug dependency case.
- Regulators may know from the outset that a sanction of longer than 12 months is required. Again, in the example of alcohol or drug dependency cases, it is recommended that a registrant demonstrates abstinence for at least 12 – 18 months. A limit of 12 months may introduce more review hearings and cost to the regulator, and increased burdens on the registrant.
- Registrants may not always comply with sanctions, or there may be other reasons why the initial sanction is not working, so regulators need to have the power to vary the Final Measure sanction on review (e.g. varying from suspension to erasure). See also comments at Q13 Part D on case review.
- Lastly, there are High Court cases (e.g. Council for the Regulation of Health Care Professionals v GDC & Anor (Fleischmann) [2005] EWHC 87 (Admin), and GMC v Saeed [2020] EWHC 830 (Admin)) involving criminality where it has been concluded that a registrant's sanction should last as long as their sentence (e.g. the length of a Community Rehabilitation Order) to protect the public and maintain confidence in the professions.

Based on the information provided, we recommend - without prejudice to any registrant's right to request a review and have a panel consider varying or removing conditions if there has been a material change in circumstances - that:

- Panels should be able to impose conditions and suspensions for a longer period than 12 months. The GDC is currently able to apply substantive conditions for a maximum period of 3 years and we seek to retain this ability following regulatory reform.
- Regulators should be able to vary the sanction on review if the initial sanction is not fulfilling its public protection purpose.
- Extensions should be able to be granted when there has been no change in circumstances.

**(Q15) Do you agree or disagree that the powers in the draft order on reviewing interim measures are proportionate and sufficient for the safe and effective regulation of AAs and PAs? Please explain your answer.**

We disagree for the reasons set out below.

## *A) Referrals to panel*

The draft order outlines that a CE may refer to a panel for an interim measure (IM). When a panel applies an IM, the CE must review the IM before 6 months and again before 12 months. An IM can be imposed for a maximum of 18 months, after which the regulator must apply to the High Court for an extension. We agree with this process in principle as it provides more flexibility and responsibility to the CE to oversee the IM. However, there will be circumstances where a referral to a panel is necessary (for example, when the registrant contests the regulator's sanction

submission). Therefore, it is necessary for panels to have the power to review IMs, even if this is not the process followed in every instance. It is not clear from our reading of the order that this power is currently provided for; we recommend that it should be.

### *B) Revision of Interim Measures*

Under these proposals, if there has been a material change in circumstances, or an error made in fact or law, the 'Regulator' may revise the IM (however, see issues around case reviews and the revisions model explained at Q13 Part D and Q17). The regulator cannot revise the length of the order.

We would recommend the inclusion of a provision for applying a subsequent measure on review in the event of non-compliance with an IM, varying the measure where necessary (e.g. varying conditions to suspension). This is relevant to Schedule 4 Paragraph 6 pertaining to the regulator's rule-making powers for non-compliance.

### **(Q16) Do you have any additional comments on 'part 4: fitness to practise' in relation to the drafting approach as it would apply to all regulated healthcare professionals?**

Regulatory reform offers an opportunity to create an innovative and flexible framework around the ways in which we operate. Although these FtP proposals provide regulators with much more flexibility in how they manage the FtP procedure (subject to legislative clarity around the initial assessment stage) – and this could certainly lead to considerable improvements from where we are now – they still lock regulators into an FtP model rooted in legalistic processes, which may ultimately limit the scope of potential benefits to the public, registrants and regulators. There may be other ways to design an FtP model which allows for innovation and results in further improvements to FtP experience and outcomes.

### **Part 5: Revisions and appeals**

### **(Q17) Do you agree or disagree that the powers in the draft order provide the GMC with proportionate and sufficient powers in relation to the revision of decisions concerning the regulation of AAs and PAs? Please explain your answer.**

We disagree.

This commentary is in response to both Q17 (regarding revisions) and Q18 (regarding appeals), as powers for revisions and powers for appeals are linked in the drafting. Therefore, this response also applies to Q18.

It is critical that any decision a regulator makes which affects the rights of others should be open to review and appeal, and that the regulator has an agile way to change decisions before reaching appeal stage where appropriate. However, the approach for revisions and appeals in the draft order is very problematic and needlessly burdensome for appellants and regulators, for the reasons below:

- Taken together, the revisions and appeals processes incorporate multiple stages (broadly speaking – the initial decision, followed by its possible revision, then an appeal to an internal panel against the decision, and then an appeal to the court against a panel decision), which carries the risk of protracted decision making.
- The drafting has the effect that two separate review routes - one for revisions and one for appeals - are created. The routes and their interaction are convoluted and confusing to

navigate for appellants and regulators. In some instances, they appear to create circular paths – for example, decisions to revise may themselves be revised or appealed.

- There is a risk of a disproportionate burden of work and increased risk of legal challenge associated with revisions in particular. This is because the draft and policy commentary suggest that someone may in effect apply for or request a revision – the process for which confers a right to make representations in all cases - before requesting an appeal. This could lead to the revisions route being treated as the appeal route, potentially many times over, ahead of the appellant electing their right to appeal. Further, anyone may request a revision, whereas only specified persons have a right to appeal. Though the draft provides for regulators to set in rules circumstances in which a revision may not be made, it would be difficult to balance the need for regulators to have the freedom to reflect on and revise their decisions with the need to limit inappropriate ‘applications’ for revisions.
- The proposed model adopts a ‘one-size-fits-all’ approach for regulatory decisions across different functions. This results in disproportionate or unworkable outcomes in different areas. For example:
  - **Registration:** The registration approvals process consists of multiple decisions in the same process. These different types of decisions all appear to be subject to revision and appeal, which could be disproportionate if there were requests to revise or appeal any number of those decisions within a single case.
  - **Restoration:** If an application for restoration made under the two-step process at Article 6(1)(a) is refused and an appeal is made against this, the appeal provisions result in two different pathways. The High Court would consider the fitness to practise issue, whereas an internal panel, followed by the County Court, would consider the registration standards issue.
  - **Fitness to Practise:** It is unclear whether the revisions model is meant to accommodate case reviews. If so, it is problematic as under the proposals it is unclear to what extent a revision can be revised (e.g. how far a regulator could vary measures imposed), and in certain instances measures may not be extended, even when an extension may be the most appropriate outcome if a registrant’s fitness to practise remains impaired. Additionally, the purpose of a case review should be to assess a professional’s fitness to practise at that current time; whereas a ‘revision’ would be to review the decision in which the original measure was imposed. See further comments at Q13 Part D.

The absence of the initial assessment stage for FtP raises the risk of removing both the regulator’s ability to revise decisions, as well as the appeal rights of patients and registrants, should a decision be made before those permissible under Article 9.

- **Education and training:** See our comments at Q2 Part C.
- The grounds for revisions – an error in fact or law, or a material change in circumstances – are not necessarily appropriate for the types of decisions being revised. Further, grounds for appeal are only set for certain types of appeal, leading to inconsistencies in the overall approach.
- We consider the proposed power under Article 11(2)(c) for a regulator to revise an appeal decision of the court when the court’s decision has been to ‘substitute for the decision under appeal a decision that could have been made’ is inappropriate.

We strongly recommend that the model for revisions and appeals is amended to address the issues above, and to provide for appropriate processes for challenging the different kinds of decisions which are made across different regulatory functions.

As part of this, we seek an outcome where revisions are distinct from appeals in that they are at the regulator's own discretion at any time, and not 'open' for others to request, so forming part of the regulator's own review mechanisms. An appellant should be able to request an appeal, and a power to revise should enable the regulator to assess whether or not to revise the decision in question. If the regulator then does not think a revision is appropriate, then the case should be handled as an appeal.

**(Q18) Do you agree or disagree that the powers in the draft order provide individuals with proportionate and sufficient appeal rights in respect of decisions made by the GMC and its independent panels relating to the regulation of AAs and PAs? Please explain your answer.**

We disagree.

See our response to Q17 which applies here.

**(Q19) Do you have any additional comments on 'part 5: revisions and appeals' in relation to the drafting approach as it would apply to all regulated healthcare professionals?**

There is added complexity for GDC regarding specialist list appeals (for the specialties of orthodontics and oral surgery) due to retained EU legislation, which will need to be accounted for in GDC order. We will need to consider the effect of proposals on the European Primary and Specialist Dental Qualifications Regulations 1998 and any interaction with the end of the EU Exit stand-still period.

## **Part 6: Miscellaneous**

**(Q20) Do you agree or disagree that the offences set out in the draft Order are sufficient to ensure public protection and to maintain public confidence in the integrity of the AA and PA professions? Please explain your answer**

We disagree and urge caution that the approach for offences in future GDC legislation must differ from that in the draft order, to enable risks arising from the unique dental context to be effectively addressed.

We are concerned that the registration related offences specified in the draft order are intent offences, when we currently operate on a basis of strict liability for illegal practice cases. It is understood that the rationale may be that this provides a means for proportionate resolution of concerns when there is no intent to deceive; however within our current strict liability model, the [GDC's prosecution policy](#) provides alternatives to resolving concerns through criminal prosecutions and as a result there are already opportunities to take consistent and proportionate action when the GDC is assured that the public is protected and there is ongoing compliance with the Dentists Act. Therefore, there is a significant risk that the burden of proving intent becomes an inappropriate barrier to enforcement action, which in fact counters efforts to protect the public.

The GDC is firm in its position that strict liability offences are a more appropriate means to offer protection to the public from illegal practice in the context of dentistry. This is because the nature of illegal practice in dentistry is different to some other professions where practice mostly takes

place within the managed sector and titles are not protected. Examples of features of the dental context which illustrate how different types of public protection risk arise, include that:

- A significant proportion of dentistry takes place in private settings. There is an increasing incidence of new models of dental practice (including cosmetic dentistry) becoming more accessible to members of the public through disruptive business models. The business models we have seen and taken action upon include risk of harm from uninformed and unqualified individuals establishing themselves, or being established through a parental organisation, in remote or pop-up services.
- There is still a precision of meaning attached to dental professional titles – and ‘dentist’ especially – which has been lost in respect of some other professional titles. For example, there are circumstances in which people refer to themselves or others as ‘doctor’ or ‘nurse’ without being registrants and without any intent to deceive. That is not the case with ‘dentist’, where it is not easy to think of benign circumstances in which somebody describes themselves as a dentist without being one. That clear delineation has value on both public policy and public protection grounds and is a further reason to treat the misuse of such titles as strict liability offences.

From 2017-2022, the GDC received an average of around 600 concerns per year raised by the public in relation to the illegal practice of dentistry. These types of concern range from reports of illegal tooth whitening to reports of suspended or erased registrants continuing to practise despite imposed restrictions. The GDC’s rigorous [prosecution policy](#) sets out the approach to be taken when considering such concerns. In the first instance the GDC will seek to dispose of matters in the most appropriate and proportionate way which typically results in issuing a warning letter or conducting a compliance visit. Notwithstanding this, the GDC receive a number of complaints each year which warrant prosecution in the criminal courts. Therefore, we consider strict liability offences essential to the model for public protection in dentistry.

We understand that DHSC will be working separately with the GDC to review the additional GDC-specific offences set out in Part IV of the Dentists Act. For clarity, these are offences for the practice of dentistry and carrying on the business of dentistry by someone not registered or exempted from the prohibition – again, indicating the distinctive nature of dental practice and the real risk of illegal practice – which will be crucial to retain in our future legislation.

We would be glad to discuss in further detail with DHSC the approach to offences for the GDC, to ensure our future framework preserves existing mechanisms proven to protect the public.

**(Q21) Do you have any additional comments on ‘part 6: miscellaneous’ in relation to the drafting approach as it would apply to any regulated healthcare professionals?**

See our comments at Q2 part C, with regards to the opportunity to make representations in the education and training context.

### **Schedule 1: The regulator**

**(Q22) Do you agree or disagree with the proposed powers and duties included in Schedule 1, the regulator, in relation to AAs and PAs? Please explain your answer.**

We disagree with, or question, two areas in particular.

*A) Principle of targeting regulatory activity only at cases in which action is needed*

Under Schedule 1 Paragraph 3(1)(b)(iii), the regulator must have regard in exercising its functions to “the principle that regulatory activity should be targeted only at cases in which action is needed”.

This risks the suggestion that regulators should not be focussing on preventative work in upstream regulation – which aims to reduce the risk of harm to patients and the public before concerns are raised – when in fact, the opposite is true.

Regulation is effective to the extent that it does not involve FtP action being taken in individual cases. As far as possible, regulatory activity should be targeted so as to minimise dependence on FtP for its effectiveness. It is vital that reforms do not have an adverse effect on regulatory efforts towards upstream regulation.

It is in circumstances where concerns have been raised specifically that regulators should target their activity towards cases where action is needed to protect the public from risk(s) – in effect, relatively more serious cases – to promote a proportionate and risk-based approach with appropriate public protection outcomes.

We would therefore recommend that the phrase “regulatory activity” is replaced with “Fitness to Practise activity” or similar.

*B) Co-operation with stakeholders*

Under Schedule 1 Paragraph 3(1)(d), regulators must co-operate with stakeholders concerned with the employment, education or training, or service provision, of professionals. The GDC currently has duties to co-operate with these groups, but additionally with regulators and organisations related to the NHS. It is unclear whether the stakeholder categories provided for in the draft order cover regulators and NHS organisations, and it would be helpful for this to be made explicit in the drafting.

**(Q23) Do you have any additional comments on Schedule 1, the regulator, in relation to the drafting approach as it would apply to all regulated healthcare professionals?**

We acknowledge that the draft order does not include a full governance and operating framework, as the GMC’s overall governance framework will continue to be legislated for under the Medical Act 1983 until reforms for doctors come into effect. We will gladly review DHSC’s proposals for governance and operating reforms in their entirety when they are consulted upon at a later stage.

**Schedule 2: Listed offences**

**(Q24) Do you have any comments on schedule 2, listed offences?**

We agree that the listed offences are not compatible with registration. However, there is other criminal behaviour which would be relevant for the regulator to consider under FtP processes, and which may also be incompatible with registration. It is essential that the inclusion of the list at Schedule 2 does not impact the regulator’s ability to challenge the consideration of, or request information about, any other offence.

We consider it would be helpful if the order was explicit in:



- providing for regulators to refuse applications for first registration made by persons who have been convicted of a listed offence
- providing for regulators to refuse applications for restoration made by persons removed from the register for a listed offence
- giving regulators the ability to hold a conviction as finding of fact, so that there is no further need to gather the evidence behind the conviction in question in order to progress to or prepare for hearing.

### **Schedule 3: Evidence gathering, notifications, publication and data**

**(Q25) Do you agree or disagree that the powers in the draft order enabling the GMC to gather, hold, process, disclose and assure information in relation to the regulation of AAs and PAs are necessary and proportionate for meeting its overarching objective of protecting the public? Please explain your answer**

We disagree, the reasons for which are set out below.

#### *A) Evidence gathering – assurance processes*

In principle, we support the intent behind the powers at Schedule 3 Paragraphs 7(1)(a), 7(2) and 7(4) which would enable us to design and operate assurance processes as proportionate to the level of risk in different circumstances. For example, as well as ongoing assurance processes for registrants and education and training providers, it appears we could operate a one-off assessment on somebody's first entry or restoration to the register to determine that the relevant standards are met, or a particular process to evaluate a professional's standards after prolonged clinical absence (i.e. a 'return to practice' type model). However, there are several areas of the drafting which cause concern, particularly around the mechanisms for periodic assurance processes.

We understand from the drafting that periodic assurance processes for registrants could be delivered in a range of ways, with requirements, frequency and procedure determined by the regulator. We also believe that the intention is that there is no obligation for all regulators to deliver the medical model of revalidation (though we welcome the flexibility for this as an option), and that the order should be accommodating of different models for registration renewal. However, the proposals suggest the GDC would have to significantly enhance the requirements of its existing [CPD/renewal process](#) in order to meet new legislative requirements. This is because in the drafting it appears that periodic assurance processes must cover all standards set under Article 3, which would include all of the registration standards at Article 6(2)(c)(i), in addition to any other standards set under Article 3(1)(b) which we assume may cover CPD requirements. It is also unclear whether the steps the regulator considers necessary for evaluation purposes could be limited or non-existent in some circumstances.

Moreover, the general issues with registration standards, as described in our response to Q4, also manifest in the context of periodic assurance – for example, it is difficult to understand whether any or all of the standards for education and training, knowledge, experience and skills, could be met by a CPD model, or the extent to which additional evidence against those standards would be required; and it is unclear how we could assess categories such as performance – unless by proxy measures or declarations – without a costly and distributed model. All of this means that regulators could be unintentionally forced towards a model much closer to revalidation, rather than purposefully opting for that.

In the context of dentistry, the structure of the system that delivers care to patients is unique and very different from the medical system. A much greater proportion of dental professionals than medics work in single practices or exclusively in private care, without the same range of support mechanisms for clinical governance that may be associated with large NHS organisations. Therefore, the way the dental system is organised does not readily lend itself to a true revalidation model.

With regards to the periodic assurance processes in the education and training context, we would like there to be an explicit power to enable regulators to appoint persons to visit providers, for example for monitoring purposes. It is not clear enough in the draft whether, when taken together, incidental powers and rule-making powers to set the procedure for evaluating standards would allow us to appoint and pay visitors.

#### *B) Evidence gathering – fitness to practise*

At Schedule 3 Paragraph 7(1)(b), the power to take steps as necessary to evaluate whether a person's fitness to practise is impaired cannot be linked to the initial assessment stage of FtP, as that stage has not been made explicit on the face of the order (see comments at Q12). It is extremely problematic that we may not have a clear basis for linking evidence gathering powers to the earliest part of the FtP process where in most circumstances the most value would be derived from investigation. It should also be made clear who these investigatory powers are allocated to.

#### *C) Notifications*

The drafting of Schedule 3 Paragraph 2 is very prescriptive compared to other parts of the order, and we consider that much of the detail could be ascribed in rules to allow the flexibility required for notifications in different circumstances.

With regards to FtP notifications, the absence of the initial assessment stage in drafting, taken together with the notification provisions at Schedule 3 Paragraph 2(1)(c), may force regulators to notify various parties, including the registrant's employer, of a CE decision on every occasion that a concern is raised – even when this is closed without action. This is unfair on registrants where no action is taken, as simply the receipt of the notification could prejudice employers through suggestion of regulatory activity.

#### **(Q26) Do you have any additional comments on Schedule 3, evidence gathering, notifications, publication and data, in relation to the drafting approach as it would apply to any regulated healthcare professionals?**

Under Schedule 3 Paragraph 5(1)(e), the regulator must publish guidance as to what amounts to impairment of fitness to practise. It is critical that there is clarity around the nature of this guidance to prevent the risk of constraining decisions on impairment in the FtP process. Assuming DHSC share the desire to avoid that risk, our assumption is that this guidance would relate to thresholds around initial assessment and case examiner stages, or the circumstances which could (or would never) give rise to an allegation. However, clarity is sought here.

See other comments at Q7 Part B, pertaining to Schedule 3 Paragraph 4, which are relevant to this question.

## Schedule 4 – Rule making powers

**(Q27) Do you agree or disagree that the draft Order provides the GMC with sufficient and proportionate rule making powers to enable it to effectively maintain a register of AAs and PAs who are safe to practise? Please explain your answer.**

We disagree. We have responded to this question and Q30 together. Therefore, this response also applies to Q30.

It is difficult to comment on the sufficiency and proportionality of rule-making powers, when in many cases the powers in the main parts of the order to which they relate – or should relate – are problematic or absent. Such powers are indicated in our responses to various other consultation questions. Though we very much welcome the ability to set our own rules across the range of regulatory functions, and the great degree of flexibility that brings, the intended benefits of that flexibility must not be fettered by restrictions or complications in the overarching processes set out in the order, or a lack of clarity in the drafting.

In particular, we are extremely concerned that the omission of an initial assessment stage for FtP on the face of the order means we would be wide open to challenge if we were to - as DHSC suggest in their policy commentary - make rules in relation to this stage under the rule making power for FtP procedures at Schedule 4 Paragraph 3(1)(a).

**(Q28) Do you agree or disagree that the draft order provides the GMC with proportionate and sufficient rule making powers to address non-compliance of AAs and PAs? Please explain your answer.**

We disagree due to the issues around the powers to review or revise measures, as already commented on at Q13 Part D, Q14 Part B, Q15 Part B and Q17. We must have the appropriate powers to vary or extend sanctions, to enable rules as to non-compliance to have the appropriate effect.

**(Q29) Do you agree or disagree with the provisions set out in the draft order for the setting and charging of fees in relation to the regulation of AAs and PAs? Please explain your answer.**

We disagree, based on the risk associated with varied interpretation of the phrase ‘taking one year with another’ in different organisational contexts.

We must be absolutely sure that the provision at Schedule 4 Paragraph 7(2), which requires that fees must be “*set with a view to ensuring that, so far as practicable, the regulator’s fee income does not exceed its expenses (taking one year with another)*” does not compromise our financial freedom as a wholly independent regulator, nor interfere in any way with our ability to set requirements for, hold and manage long-term reserves, or to balance budgets. We take the meaning of the phrase ‘taking one year with another’ to signal recognition that there will be fluctuations in regulators’ income and expenditure year-on-year, but have significant concerns that it may compromise effective medium term financial management.

The system of professional regulation in dentistry is funded almost entirely from fees paid by registrants. The GDC’s [fee setting policy](#) contains three principles to which the organisation adheres:

- **Fee levels should be primarily determined by the cost of regulating each registrant group:** We will seek to minimise the ways in which registrants fund regulatory activity that

is not generated by them by removing, as far as practicable, cross subsidy between different groups. We will do this by allocating costs, as far as possible, where they fall. Where a degree of cross subsidy is necessary, we will explain this through our policy.

- **The method of calculating fee levels should be clear:** We will be open with registrants about how we allocate the income we receive from them and why, and provide sufficient information about cost drivers, giving them the opportunity to contribute to the debate. We will seek to show a clearer link between fee income and regulatory activity.
- **Supporting certainty for registrants and the workability of the regulatory framework:** We need to make sure that decisions on the allocation of costs do not lead to undesirable outcomes in the form of unacceptably high or variable costs for some groups of registrants. For example, in determining whether cross subsidy is necessary or desirable we will need to consider the impact on the volatility of fee levels (i.e. how much small changes in workload would cause the fee to change). This is likely to be of particular relevance to small registrant groups, where distribution of costs among small numbers of registrants has the potential to give rise to significant levels of volatility (and therefore uncertainty) and/or prohibitively high fees.

Currently, as described in the policy, the GDC consults upon the high-level objectives and associated expenditure plans that underpin our annual retention fee every three years. This longer-term approach to fee setting provides certainty to registrants as well as giving us the flexibility and accountability to respond to changing economic circumstances. Over any three-year period, reserves are an essential part of ensuring the financial viability of the GDC and allow us to smooth any in-year changes in cost, reducing the need for exceptional changes to fees.

We consider that our existing policy and longer-term approach to fee setting is wholly appropriate and aligns with the DHSC's overarching policy intent in this area. It is essential that the legislation does not create an unintended obstacle to prudent financial management.

**(Q30) Do you agree or disagree that the rule making powers set out in the draft order will enable the GMC to deliver the safe and effective regulation of AAs and PAs? Please explain your answer.**

We disagree. See our response to Q27.

**(Q31) Do you have any additional comments on Schedule 4, rules, in relation to the drafting approach as it would apply to all regulated healthcare professionals?**

It is also impossible to comment on the sufficiency and proportionality of rule-making powers for the GDC specifically, when we know that our reformed legislation will vary from this template and will include bespoke powers.

## **Schedule 5: Consequential amendments**

**(Q32) In relation to Schedule 5, consequential amendments, do you have any comments on how the draft legislation delivers the policy intention in relation to AAs and PAs?**

We understand that the consequential amendments required for the reform of each regulator will have to be determined on a case-by-case basis.

**(Q33) Would you like to provide any further comments on the draft order?**

As per the comments in the introductory section of our response, the way in which this order has been constructed is unclear and challenging to follow in many places, raising risks around variation in interpretation and application. See sections 1.16-1.19 for further details.

**Costs, benefits and equalities analysis**

**(Q34) Do you think there are any further impacts (including on protected characteristics covered by the public sector equality duty as set out in the Equality Act 2010 or by section 75 of the Northern Ireland Act 1998) from the legislation as currently drafted?**

There is a risk that overseas qualified candidates will be disadvantaged by the proposed framework as a result of the following factors:

- Risks arising from the fact that the distinction between UK and international processes for education, training and registration is not drawn in the drafting, and there are language conflicts with wider existing legislation relevant to international registration.
- The inclusion of performance, conduct and ethics within the standards to meet for registration – for which overseas applicants are less likely to have the requisite evidence against all categories due to differences in international jurisdictions.

See additional commentary at Q1 Part A and Q4 Parts A and D.

There is also a risk that dental professionals who are affected by health issues or disabilities which subsequently give rise to an FtP concern may be disadvantaged by the proposed FtP process. This is because within it, health is not a separate ground for action, posing barriers to the appropriate management of health cases, and ultimately equitable outcomes for the registrants involved.

See additional commentary at Q13 Part B.

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