General Dental Council

GDC consultation response

Department of Health (Northern Ireland) consultation on raising a concern in the public interest (whistleblowing) framework and model policy

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Introduction

The General Dental Council (GDC) is the UK-wide statutory regulator of over 114,000 members of the dental team, including over 43,000 dentists and 71,000 dental care professionals (DCPs). In Northern Ireland we regulate around 2,300 DCPs and 1,700 dentists.

An individual must be registered with the GDC to practise dentistry in the UK. Unlike other health professional regulators, we register the whole dental team, across the four nations of the UK, including dental nurses, clinical dental technicians, dental hygienists, dental technicians, dental therapists, orthodontic therapists and dentists.

Our primary objective is to protect the public, and in doing so to:

- Protect, promote and maintain the health, safety, and well-being of the public.
- Promote and maintain public confidence in the professions regulated.
- Promote and maintain proper professional standards and conduct for members of those professions.

All patients should be confident that the treatment they receive is provided by a dental professional who is properly trained, qualified, and meets our standards. To achieve this, we register qualified dental professionals, set standards for the dental team, investigate complaints about dental professionals' fitness to practise, and work to ensure the quality of dental education.

The GDC is a ‘prescribed person’ under The Public Interest Disclosure (Prescribed Persons) (Amendment) Order (Northern Ireland) 2022 for matters falling within its regulatory responsibilities.

We welcome the opportunity to respond to this consultation and we express support for the proposed framework.

While our role includes considering concerns about dental professionals, we have been working in recent years to shift our efforts away from regulatory enforcement and toward fostering professionalism and open learning cultures which this framework and model policy encourages. Furthermore, in strategic aim two of our current Corporate Strategy, we commit to working with the professions and our partners to ensure that patients and the public are able to raise concerns with the agency best placed to resolve them effectively and without unnecessary delay.

It is of course essential to our statutory function that the most serious cases are referred to us as the regulator of dental professionals, and we will continue to work with the Department of Health in Northern Ireland to develop guidance to underpin this new framework and model policy, to ensure that patients and staff are clear which types of cases merit this type of action.

Consultation questions and the GDC's responses

1. **Do you agree our approach to the definition of the term "Raising a Concern" is successful in clearly demonstrating the breadth of the concerns which fall within the scope of the model framework and when the process for raising a concern should be used?**

Disagree.

Please include further details below:

Our understanding of the Public Interest Disclosure (Northern Ireland) Order 1998 and the Employment Rights (Northern Ireland) Order 1996 is that a person raising a concern or 'blowing the whistle' must reasonably believe that:

a) they are acting in the public interest and

b) that they reasonably believe that the disclosure tends to show past, present or likely future wrongdoing falling into one or more of the following categories:

- criminal offences (this may include, for example, types of financial impropriety such as fraud)
- failure to comply with an obligation set out in law
- miscarriages of justice
- endangering of someone's health and safety
- damage to the environment
- covering up wrongdoing in the above categories

We think that the definition provided at paragraph 2 is slightly vague and potentially misleading. Whilst the definition of the term 'public interest' is broad and the distinction is made between raising concerns in the public interest and personal grievances and complaints is made at paragraph 6, we think that this distinction should be made clearer from the outset. It may be helpful to provide practical guidance on the interpretation of the meaning of 'public interest'. This could be achieved with references to material on the Protect website which uses case studies to illustrate the difference between a 'public' and 'private' concern.

Furthermore, the example concerns referenced at paragraph 5 should ideally reflect primary legislation more accurately, acknowledging that the list is not exhaustive or restrictive. Staff should be directed to seek advice from an appropriate manager or colleague if they are unsure.

2. **Do you agree that the guidance within the model framework is clear in addressing legislation and best practice documents?**

Agree (with some suggestions for improvement).

Please include further details below:

We are unable to comment in detail on whether the model framework itself reflects primary legislation and guidance accurately. However, we think that applicable primary legislation and relevant guidance (such as the Guide to Public Interest Disclosure Legislation) should ideally be referenced at the start of the model framework to improve clarity.

There may also be an opportunity within the framework to set out that regulated professionals must adhere to the standards set by individual professional regulators. For example, in our standards for the dental team we set out various relevant standards including the requirements that dental professionals:

- must act promptly if patients or colleagues are at risk and take measures to protect them (standard 8.2) and
- if dental professionals employ or manage a team, they must encourage and support a culture where staff can raise concerns appropriately and without fear of reprisal (standard 8.3).

We are not suggesting that all standards set by individual regulators are listed. Rather, that it is clarified that regulated professionals must refer and adhere to the guidance and standards set by their regulator as well as the framework and model policy.

There may also be an opportunity to highlight (dependent on implementation timescales) any new statutory Duty of Candour introduced in Northern Ireland, which was consulted on between April and August 2021. Our full response to this consultation can be found here.

3. Do you agree that the monitoring arrangements stipulated within the framework are sufficient in gathering data that will be effective in determining the success of the process?

Agree.

Please include further details below:

We agree with the monitoring arrangements proposed, however, in practice a major component of an open learning culture is the support available for staff working in an organisation. Opportunities to reflect, clear guidance, and effective systems for the dissemination of learning, underpin safe cultures and avoidance of blame. As such, as well as HSC organisations reporting annually and analysing concerns on a regular basis, organisations should also endeavour to promote an open learning culture and share learning from concerns.

At paragraph 37, titled, 'Audit, review and refresh', there is guidance on how HSC organisations should review their arrangements for raising concerns. It would be helpful if a link could be made between this section and the following section on 'Reporting and monitoring' to ensure that all the components listed at paragraph 37 are considered as part of the overall monitoring process.

The framework and model policy focuses on local monitoring requirements. Additional value may be derived from national monitoring requirements, for example directly to RQIA, to further ensure that monitoring within local services takes place, share learning and encourage a consistent approach across services, and to gather data to determine the success of the policy and framework at a national level.

Finally, in the context of dentistry, the governance and oversight structures which are described in the proposed framework (non-executive directors (NEDs), audit committees), are highly unlikely to be in place, particularly in small dental practices. In the General Dental Statistics for Northern Ireland annual statistical report 2020/21 it was reported that in March 2021 there were an average of 3.1 dentists per practice. As such both implementing and monitoring the new framework may be more challenging in a small dental practice setting. It is essential to

recognise the differences in governance and oversight structures within different HSC settings and suggest alternative best practice approaches if possible.

4. **Do you agree that the approach set out within the framework clearly demonstrates that the process ensures all staff and others who raise a concern will receive appropriate protection?**

Agree (however have also highlighted the importance of promoting an open learning culture in enabling the process).

Please include further details below:

As stated above, for individuals to feel protected and supported when raising concerns, it will be important first to create an open learning culture. Providing best practice guidance to promote such a culture alongside this framework would support staff to feel protected.

The policy and framework assures legal protection in the event of raising a concern, however, assuring psychological safety achieved through supportive learning cultures is equally as important.

5. **Do you agree that the approach taken in designating roles and responsibilities within the organisation in relation to handling the process for raising a concern will establish confidence in the integrity of the process?**

Disagree.

Please include further details below:

We know from our own research that the role of regulators is not widely understood and often confused with trade unions or professional bodies. We note that some but not all healthcare professional regulators have been listed under 'Role of Trade Unions and other Organisations.' It would be better to include all regulators under a separate heading to enhance clarity over the unique and different role that we perform to protect the public.

As mentioned in our introduction, one of our statutory functions is to investigate concerns about dental professionals. Whilst we are supportive of encouraging and promoting local resolution of concerns wherever possible, we would be happy to work with the Department of Health in Northern Ireland to set out the scenarios in which a concern ought to be raised with us as the regulator of dental professionals.

It would be helpful to set out the role of the RQIA as the systems regulator, which is distinct from the role of healthcare professional regulators.

We do not agree with the last paragraph of section 7 ('Raising a concern externally') of the model policy at Appendix A, which could be read as implying that without the advice of a union it may be unsafe to raise a concern with an external agency. We would not wish for there to be any unnecessary barriers to raising concerns, nor a suggestion that direct contact with an external agency is unsafe.

It will also be important to ensure that this new policy and framework can be adapted for any type of organisation/provider/service/delivery context as roles/titles may differ, as will governance and oversight arrangements.

6. **Do you agree that the process laid out in appendix B Is clear and comprehensive?**

Agree (however have highlighted that there are overlaps between what we investigate at the GDC and what is prescribed in legislation regarding whistleblowing concerns).

Please include further details below:

There are clear overlaps between what we investigate at the GDC and whistleblowing concerns as prescribed in legislation. We investigate concerns about the ability, health or behaviour of a dental professional that suggest the professional could cause significant harm to patients, colleagues or the general public, or undermine public confidence in the dental profession. Some common examples include serious or repeated mistakes in patient care, fraud, discrimination and any serious criminal offences or convictions.

As noted above we would be happy to work with the Department of Health in Northern Ireland to set out the scenarios in which a concern ought to be raised with us as the regulator of dental professionals, or at local level in the first instance.

7. **Do you agree that the process laid out in appendix B successfully ensures individuals who raise a concern are given appropriate feedback in a timely manner?**

Disagree.

Please include further details below:

We think that the process laid out in appendix B will support the requirement for appropriate and timely feedback to an individual who has raised a concern, rather than successfully ensuring it in all cases. This is because, the process indicates that the type of feedback and timeframes in which feedback will be given will be determined on a case-by-case basis.

8. **Do you agree that the approach to monitoring and reporting within the framework ensures that lessons learned will be identified and applied appropriately to enable improvements in service?**

Disagree**.**

Please include further details below:

As mentioned in response to question three, this guidance should also prompt organisations to consider action that promotes an open learning culture and effective sharing of learning from concerns.

A clearer link could be made between paragraph 37 on ‘Audit, review and refresh’ and paragraph 38 on ‘Monitoring and reporting.’

9. **Do you agree that the approach taken in this framework creates a safe process where staff can raise concerns within a culture of openness and transparency where learning for improvement will be encouraged?**

Agree (however with suggestion that further practical guidance on how to promote an open and transparent culture would be beneficial, alongside regular review of organisational culture by nominated NED or equivalence for organisations that cannot implement similar oversight structures).

Please include further details below:

The framework, as written, sets out a safe process where staff can raise concerns within a culture of openness and transparency where learning to drive improvement will be encouraged.

However, further practical guidance could be provided to illustrate best practice in developing open learning cultures.

Furthermore, whilst it is stated in Appendix B that a nominated non-executive director (NED) will hold responsibility for the oversight of the organisation's culture of raising concerns, it may be helpful to stipulate that an organisation's culture of raising concerns is subject to review so that improvements, based on feedback from staff, can be made on a continuous basis. As mentioned in response to earlier consultation questions, it will be essential to recognise that not all settings will have NEDs or the same governance structures and, as such, alternative oversight mechanisms may need to be established.

10. Do you agree with the outcome of the Impact Assessment Screenings? Have you any comments on either the Equality/Human Rights or Rural screening documents? Have you anything you believe we should be considering in future Equality/Human Rights or Rural screenings or future impact assessments?

Agree (with a further suggestion on how it could be illustrated in the policy/framework that closed cultures in organisations lead to harm, including possible human rights breaches).

Please include further details below:

The findings of the Inquiry into Hyponatraemia Deaths in Northern Ireland, and abuse at Whorlton Hall, Winterbourne View, Mid Staffordshire Hospital and other services have highlighted the extremely damaging effects a service with a closed culture can have on everyone involved in the delivery and receipt of care across the UK.

The Care Quality Commission (CQC) defines a closed culture as 'a poor culture that can lead to harm, including human rights breaches such as abuse'. In these services, people are more likely to be at risk of deliberate or unintentional harm. Whilst we recognise that CQC has no remit over healthcare services in Northern Ireland, its work undertaken to date to understand closed cultures has shown that people using services that have closed cultures are more likely to be at risk of abuse, avoidable harm and breaches of their human rights.

We note that reference is made to the findings of the Mid Staffordshire Hospital report 2013 in the framework. As a key element of this new framework is to promote the importance of an open and transparent culture in the context of raising concerns, reference could also be made to the incidents which took place at Whorlton Hall and Winterbourne View to make the point that the absence an open and transparent culture can lead to serious harm and potential human rights breaches.

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