General Dental Council

GDC consultation response

DHSC consultation (applies England only) Leading the NHS: proposals to regulate NHS managers

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All enquiries regarding this publication should be sent to:

General Dental Council
37 Wimpole Street
London
W1G 8DQ

Phone: 020 7167 6000
Email: information@gdc-uk.org
Web: gdc-uk.org

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GDC response to DHSC consultation (England only)
Leading the NHS: proposals to regulate NHS managers

1. About the GDC

The General Dental Council (GDC) is the UK-wide statutory professional regulator of more than 125,000 members of the dental team, including over 45,000 dentists and over 79,000 dental care professionals (DCPs). As at, 15 January 2025, there were 110,131 dental professionals registered in England.

An individual must be registered with the GDC to practise dentistry in the UK. Unlike other health professional regulators, we register the whole professional 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.

We welcome the opportunity to respond to this consultation. As exemplified by the findings of several high-profile public reviews – perhaps most recently the Infected Blood and Thirlwall Inquiries – public protection and public confidence in healthcare may be strongly influenced by the decisions and actions of healthcare managers. We therefore support efforts to ensure that healthcare managers have the right values and skills for their roles, that all healthcare staff are working in cultures of honesty and openness where concerns can be raised safely and responded to appropriately, and that accountability mechanisms for managers are effective. However, it is important to consider if, where and how the proposed regulatory system for managers could work in an effective way to promote these outcomes.

We have a particular interest in any proposed approaches to regulate clinical managers (individuals in managerial positions, who are already registered with a healthcare professional regulator), and the analysis of options around the role of existing healthcare professional regulators. Analysis must properly account for the specific regulatory models and capabilities of existing regulators, and how these relate to any potential regulatory framework for managers. In principle, regulatory intervention should be set at the minimum level necessary to meet the relevant public policy objective, and the need for duplicate professional regulation of individuals should be avoided as far as possible.

Similarly, the NHS as an employer and as a service provider has a wide range of levers through its management and organisational structures to promote desired behaviours and to act when people fall short of them. Regulation cannot be a substitute for effective management

and leadership and while it may provide additional assurance, it will be important to be extremely clear about the outcomes which only regulation can provide over and above those which should in any case be achieved by other means.

2. How we have responded to this consultation

The consultation sets out questions under several topic areas. We have organised our views by most of those same topic areas in section 3 of this document.

In some instances, we have answered selected consultation questions directly. In others, we have highlighted wider considerations from a regulatory perspective.

We would be happy to provide further information to the Department of Health and Social Care (DHSC) as this work develops. We would also welcome further discussion with DHSC and other regulators around any issues in relation to the role of healthcare professional regulators in the regulation of clinical managers, or any other issues where regulatory approaches for healthcare professionals and managers would need to align.

3. Consultation response

3.1. Overall approach to the regulatory model / A professional register

A. Wider considerations

Healthcare management is already highly regulated. For example:

- the Care Quality Commission (CQC) regulates healthcare providers to ensure they are delivering safe, effective, compassionate and high quality care
- the Fit and Proper Person Test (FPPT) is a safety mechanism to prevent unsuitable board members of NHS organisations from being redeployed or re-employed across the NHS or independent sector, and
- many managers will also be subject to regulation by other professional regulators (e.g., clinical, finance or legal managers may be registered with the relevant regulators for healthcare, finance or legal professionals respectively).

So, it is important to understand why existing regulation may not be producing the optimal leadership and safety outcomes, and to identify the options for addressing any shortfall. More regulation will not in itself result in improvements to outcomes, and risks associated with over-regulation may counter efforts to protect the public. Moreover, whilst we most certainly need competent and accountable managers, there will also be situations where barriers over which they have limited control may hinder the effectiveness of even the best managers.

All of this means that it is important to consider the key elements and enablers of positive safety culture, if and how the regulation of managers could support them, and where non-regulatory initiatives would be more effective than (or necessary to complement) a regulatory regime, to optimise safety outcomes.

In line with the findings of several high-profile public reviews over the past two decades, it is widely accepted that safety incidents are reduced in open compassionate cultures, where all staff are listened to and supported to raise

concerns, and learning and improvement are prioritised over blame. Strong management and leadership are critical to fostering such cultures, in conjunction with other measures to support managers in promoting them (e.g., ensuring resources and infrastructure for continuous improvement, or the provision of mental health support for staff involved in safety incidents). Enhanced regulation may be a way of supporting the development of those leadership characteristics, but it is not the only way, and it may not be the best way.

Healthcare regulation tends not to discriminate between the NHS and private sectors. For example, healthcare professional regulators register all healthcare professionals, irrespective of where they work, and the CQC regulates providers irrespective of whether they provide NHS or private care. That is not only appropriate in principle – the regulatory system should protect patients irrespective of the organisational structure through which their care is delivered – but it is also sensible pragmatically, as the boundaries between NHS provision and private care are frequently not clear cut. Most NHS dental care, for example, is not delivered by NHS organisations or by NHS employees and there are many other areas where independent providers deliver NHS contracts.

It is therefore important to consider how any regulatory system for healthcare managers would operate consistently across both the NHS and independent sectors.

Finally, we note that proposals have been presented for managers working in England only. We would urge alignment in approach between any regulatory frameworks for managers across the four nations of the UK to promote consistency in outcomes and reduce any confusion associated with different sets of regulatory requirements. This is particularly because some members of the public cross borders to access healthcare, and some managers may work in more than one nation during their career.

B. Question: Do you agree or disagree that there should be a process to ensure that managers who have committed serious misconduct can never hold a management role in the NHS in the future?

In current models of healthcare professional regulation, where professionals have had findings of misconduct made against them through Fitness to Practise proceedings, one of several options is chosen to address the risk to the public. For example, the regulator may allow the professional to stay on the register but restrict their practice under appropriate conditions, or, in the most serious cases, the regulator may remove the professional from the register so they can no longer practise for a certain time period.

Even when a professional has been removed from the register under Fitness to Practise proceedings, they have the option to apply to restore their registration after a certain period of time, at which point another assessment of their fitness to practise is made. Where there is sufficient evidence of remediation, it may be determined that the professional's fitness to practise is no longer impaired, and they can be registered again. This would be far less likely in instances of very serious misconduct where the risk to the public continues to be high; nonetheless, the option to re-apply for registration remains and each application is assessed on the particulars of the individual case, recognising that the risk to the public may have reduced.

It would therefore seem inconsistent, and arguably disproportionate, to bar managers absolutely and without any possibility of review. That does not preclude there being certain types of misconduct considered so egregious that they would never be compatible with a person's eligibility for a management role (e.g., being convicted of certain serious criminal offences, in a similar approach to specified offences resulting in automatic removal from the register in healthcare professional regulatory reform proposals).

3.2. Scope of managers to be included

A. Wider considerations

We consider that the following factors should inform decisions and planning around the scope of managers to be included:

- As discussed in section 3.1A, it may be necessary to include managers from both the NHS and private sectors to realise the benefits of regulation across healthcare.
- Management and leadership structures vary between different parts of the healthcare system, and this should be allowed for in decisions around scope.
- The roles, responsibilities and reach of managers and leaders in different parts of the healthcare system also vary. This means that the oversight and influence of managers and leaders is much more limited in some areas of healthcare than others (e.g., healthcare professionals working in hospital settings will be exposed to more clinical governance structures and contact with senior leadership than those working in small independent practices). If the Government's intention is to use regulation to drive the promotion of safety cultures where staff are supported to raise concerns, wider initiatives may be required to support the promotion of safety cultures in areas of the system where managers have less presence or influence. Consideration should also be given to the areas in healthcare for which managers or leaders can meaningfully be held accountable for their actions.
- Decisions for inclusion may need to be based on the nature of leadership responsibilities and the potential impact of those responsibilities on patients and healthcare staff, rather than simply on job title or band, if roles under certain titles or bands are not truly comparable across the NHS or other organisations with remits in healthcare. This could also allow a regulatory system to be set up which is proportionate to the level of risk associated with managers' responsibilities.
- Risks associated with over-regulation should be mitigated by ensuring that managers are brought into regulation as proportionate to the types (e.g., financial, patient safety) and levels of risk attached to their responsibilities (e.g., it may not be proportionate to regulate more junior managers with limited decision-making responsibilities and duties which cover relatively low-risk areas of healthcare). Alongside any regulatory regime, consideration should be given to other initiatives which would support unregulated managers to develop the right skills and values and promote a positive safety culture as appropriate to their roles.

Given the organisation of the dental system, and the overwhelming majority of dentistry being delivered via independent primary care practices (either under an NHS contract or privately), we have considered the regulation of managers in that context. We note that:

- There are roughly 11,000 independent dental practices in England, providing a mix of NHS and private care. They vary in size and provide care to differently sized population cohorts.
- Most dental practices are run as small businesses, although there are also a number of larger dental corporate providers operating across England, some with responsibility for tens or hundreds of practices. Larger corporates usually have more organised leadership and management structures at practice, regional and national levels.
- According to information on UK businesses held by the Office of National Statistics, as at March 2024:
    - There were 12,945 dental practice businesses in the UK (UK businesses who have their industry classed as 'dental practice activities').
    - Of these, 78.5% (10,165) of employed fewer than 10 people, 21% (2,725) employed 10-49 people, and less than 1% (55) employed 50 or more people.
    - According to the same data source, there were 10 dental practice businesses employing 250 or more people and this set of businesses was operating across a total of 1,521 sites. In comparison, there were 10,165 businesses employing fewer than 10 people, and this set of businesses was operating across a total of 10,230 sites.
- Typically, most staff in a dental practice will be clinical and therefore already regulated by the GDC and bound by our standards. In many cases, practice managers (working at the practice level) will also be registered dental professionals, working in a dual role.
- Practice managers are often led by the practice principal (i.e. a clinician with overarching responsibility for the practice who will be registered with the GDC), and/or, if the practice is run by a dental corporate, are acting under the broader management structures of the corporate.
- In some practices there may be a relatively high turnover over of people in practice manager roles.

Whilst we recognise that dental practice managers (as well as all other members of the dental team) play a key part in fostering a positive safety culture, because of the factors listed above, it may be disproportionate to regulate those working at the practice level. The introduction of regulation may also present recruitment barriers. In general, we do not consider that it would reasonable or proportionate for dental practice managers to be regulated as such and that the combination of professional regulation of the clinicians involved and the role of the systems regulator provide adequate assurance against the risks typically encountered in those settings.

It may be worth considering if and how management and leadership positions in larger providers, provider groups or dental corporate structures should relate to a future regulatory regime.

We also note that dental practices do not have the same sort of clinical governance and oversight structures as hospitals, and dental practice teams will usually have extremely

limited exposure to leaders and managers in the broader healthcare system who have responsibilities relating to dental staff and patients (e.g. in NHS commissioning bodies or Integrated Care Boards). Therefore, as mentioned above, dental practices may benefit from wider initiatives to support the promotion of safety cultures in areas of the system where more managers have less presence or influence.

Finally, consideration should be given to where dental clinical managers and leaders should have roles and responsibilities in the healthcare system, to support the management of unique risks in dentistry and the promotion of safety outcomes. For instance, there is currently no requirement for Integrated Care Boards (ICB) to have a dental representative, despite ICBs' responsibilities to commission NHS dentistry, the carrying out of which requires sector-specific knowledge as it has significant impacts on different areas of the dental system.

3.3. The responsible body

A. Question: If managers are brought into some form of regulation, do you have an organisation in mind that should operate the regulatory system?

The type of body or bodies responsible for the regulation of healthcare managers would depend on the type of regulatory system to be implemented. As noted in section 1, the need for duplicate regulation of managers who are also clinicians (or subject to other forms of professional regulation) should be avoided as far as possible.

It may be appropriate to make an existing regulator(s) responsible for all or some of the features of a new system, providing the feature(s) were similar enough in nature to those of the regulator's existing model, the regulator had suitable capabilities, capacity and resource to manage them, and any additional responsibilities would not have a negative impact on those existing. There would also need to be appropriate mechanisms to manage any additional costs and funding required.

If multiple bodies were involved, clarity would be needed on the specific roles of each body to ensure there were no gaps or needless overlaps in the overall regulatory approach.

Please see our comments in section 3.6B on proposals for the regulation of clinical managers, which are also relevant.

3.4. Professional standards for managers

A. Question: Do you agree or disagree that there should be education or qualification standards that NHS managers are required to demonstrate and are assessed against?

Different management and leadership roles require different types and levels of knowledge, skills and experience. Further, there is a vast range of different education and career pathways people could take to gain the necessary knowledge, skills and experience for any particular role.

For the reasons above:

- Any educational standards to be met to enter a managerial position would have to account for these differences in role requirements and the range of pathways someone could take to attain the necessary standards.
- Whilst undertaking certain qualifications may support an individual to develop the necessary competencies for a managerial role, it may be challenging to develop a single formal qualification, which people must obtain to be eligible for managerial positions. Such a qualification would potentially need to result in a very wide range of learning outcomes, not all of which may be necessary for the role in question. Moreover, there is a risk that a qualification creates an unnecessary barrier to entering managerial positions, if there are other legitimate ways to gain and demonstrate the requisite knowledge and skills for the role.
- It may be possible to develop a qualification that covers only the core knowledge, skills and behaviours expected of all managers. For example, aspects of the law and ethical behaviours, rather than technical management skills which could vary between roles.

Finally, it is worth considering potential options for the role of assessment in checking that individuals who are applying for managerial roles meet the desired standards (regardless of their path to attainment) - both on entry to the role, and as part of role changes or promotions to positions with different or increasing leadership responsibilities.

B. Wider considerations

The Government's current policy position is that any professional standards for NHS managers will cover, as a minimum, the values, behaviours and competencies that managers will be expected to demonstrate.

We would expect that the values and behaviours of all managers to be similar, and that these should align with the ethical frameworks and standards of conduct of regulated healthcare professionals, given all are working in a healthcare environment. However, the technical competencies for managers are highly likely to be role and/or seniority dependent (e.g., the competencies for a Finance Lead, may be quite different to those for a People Lead; a more senior manager may be held to a higher standard than a more junior manager), and therefore we are unsure about how professional standards for managers could incorporate competencies applicable to all managers, and how managers could be fairly assessed against all competencies.

Incorporating competencies within professional standards may also have implications for which organisations can act as responsible bodies. Please see our comments in sections 3.3A and 3.6B.

3.5. Revalidation

A. Question: If a professional register is implemented for NHS managers, do you agree or disagree that managers should be required to periodically revalidate their professional registration?

If a professional register were implemented for managers, then we agree that periodic checks should be made at appropriate intervals to provide assurance that managers remain fit for registration. The standards to be demonstrated or declared during a periodic check should be proportionate to the safety risks associated with managerial roles, and the periodic checking process should be workable for the different roles and environments within which a manager may be working.

Consideration should be given as to how clinical managers would be regulated, and whether ongoing assurance that they were fit to serve as managers could be given satisfactorily through processes associated with their healthcare professional registration (e.g., an expectation to undertake Continuing Professional Development (CPD) linked to both clinical and managerial responsibilities), rather than a separate system of registration for managers. This would depend on the overall regulatory approach for managers, the standards to be assessed as part of the periodic check, and the capabilities of healthcare professional regulators. Please see further comments in section 3.6B.

B. Question: What skills and competencies do you think managers would need to keep up to date in order to revalidate?

Regardless of whether a regulatory system for managers is introduced, we support efforts to promote the continued learning and development of healthcare managers and leaders.

In the same way as healthcare professionals, we expect different managers to have different learning and development needs, depending on individual strengths and weaknesses, specific roles and responsibilities, and ongoing changes in evidence, thinking and practice. Whilst there may be some core areas of knowledge, skills and competencies to keep up to date (e.g., safeguarding policy, or the application of equality, diversity and inclusion principles), it is important that managers undertake, and are supported to secure, training opportunities which address their individual needs.

As an example, dental registrants must comply with the requirements of the GDC's CPD scheme to maintain their registration. These include undertaking a certain amount of CPD in a specified timeframe, maintaining a personal development plan, and linking CPD activities to particular developmental outcomes. Dental professionals can choose the areas of knowledge and skill which their CPD activities cover based on personal development needs, though the GDC recommends certain CPD topics which are particularly pertinent to patient safety.

3.6. Clinical managers and dual registration

A. Question: Do you agree or disagree that clinical managers should be required to meet the same management and leadership standards as non-clinical managers?

We agree that clinical managers should be required to meet the same management and leadership standards as non-clinical managers. However, a set of standards

would need to be defined that is relevant and appropriate to both clinical and non-clinical management roles.

Please see our comments in sections 3.4A and 3.4B, which highlight further issues in relation to standards.

B. Question: If you agreed, how should clinical managers be assessed against leadership or management standards?

In developing our views, we have considered the three main options set out in the consultation for dealing with regulating managers who also hold another clinical professional registration, and how these would potentially affect the GDC and dental registrants in managerial roles.

If possible, it would seem sensible to avoid dual registration to prevent risks or tensions created by individuals being subject to two regulatory regimes (e.g., two regulators investigating the same concern about an individual in different ways; confusion for clinical managers arising from the application of two sets of professional standards in overlapping contexts; confusion over roles and responsibilities amongst regulators with overlapping functions). We note that in dentistry, the vast majority of care is delivered in primary dental care environments, where the different dental professions involved in care delivery are all regulated by the GDC. This means that professional concerns resulting from a single safety incident tend to engage the GDC only, as opposed to multiple regulators for different professional groups. With a regulatory scheme for managers, were a dental incident involving dental clinical managers and dental professionals to occur, it may be more helpful for the GDC to investigate all individuals involved, rather than the managers being investigated by a separate body.

However, we emphasise that options where the GDC is involved in the regulation of clinical managers would only be possible to explore if they mapped closely to the GDC's existing model and did not deviate substantially from it. For instance:

- If clinical managers were held to the same ethical standards as dental registrants, then if concerns about clinical managers were raised in relation to those standards, they could potentially be dealt with in a similar way to concerns about dental registrants, providing it were clear what the consequences would be in relation to the managerial role. But if clinical managers were held to a set of standards which related to competencies inapplicable to dentistry or which did not align with existing dental professional standards, then we would not have the capability to deal with concerns about those standards.
- The consultation suggests there could be a qualification standard for managers (see our comments regarding the issues with this at section 3.4A). Although the GDC has a role in quality assuring dental education and training, we would not have the capacity, resource or technical expertise on management to inspect and verify management qualifications or providers.
- Under the GDC's CPD scheme, registrants undertake CPD in line with GDC requirements, based on a personal development plan. The GDC recommends, but does not require, certain CPD topics. Dental registrants make CPD

declarations as part of the renewal process to maintain their registration. Clinical managers could potentially choose (and may already be choosing) to undertake more CPD activities applicable to their leadership and management roles, as part of a periodic checking process for managers. However, the GDC is not in a position readily to quality assure management related CPD, nor does it currently operate a periodic checking process which operates like the medical model of revalidation.

Please see our comments at section 3.3A, which are also relevant.

C. Wider considerations

We note that the consultation focusses on clinical managers who by definition are already regulated healthcare professionals, but not on other types of professionals working as managers who may already be regulated elsewhere – for example legal or finance professionals. The government should also consider options for approaches to regulating other kinds of managers who are subject to existing regulatory schemes.

3.7. Phasing of a regulatory scheme

A. Question: Do you agree or disagree that a phased approach should be taken to regulate NHS managers?

Implementation should be planned to minimise the risks of unnecessary costs, delays or logistical complications negatively impacting patient safety. A phased approach could well be an appropriate approach to managing those risks.

A phased approach could offer a useful opportunity to evaluate different features and operational mechanisms of the regulatory system, so that learning could inform its ongoing development as it is scaled. It could also help managers and responsible bodies to adapt to the new system or facilitate the concurrent introduction of other measures to support improvements in safety culture and safety outcomes.

3.8. Duty of candour for NHS leaders

A. Question: If managers are brought into a statutory system of regulation, do you agree or disagree that individuals in NHS leadership positions should have a professional duty of candour as part of the standards they are required to meet?

A professional duty of candour for managers and leaders, similar to the duty already in place for healthcare professionals, would be appropriate to support cultures of openness, transparency and accountability in healthcare. We see no reason why managers and leaders should be held to a different standard to healthcare professionals with regards to candour, when their activities may impact patient or staff safety, they may have roles in responding to concerns or safety incidents, and they may be involved in communicating with staff, patients and the public.

B. Question: Do you agree or disagree that NHS leaders should have a duty to ensure that the existing statutory (organisational) duty of candour is correctly followed in their organisation and be held accountable for this?

We note that:

- the extant statutory duty of candour was originally introduced following a recommendation by the 2013 report of the Mid Staffordshire Inquiry, and that its aim was to incentivise providers to commit to an open, learning culture.
- the final report of the Infected Blood Inquiry makes a recommendation for the statutory duty of candour to be extended to NHS leaders, in particular to board members and those in executive positions.

It appears that the intention behind the duty for NHS leaders (as defined in the consultation question) would be to use individual accountability for candour as a means of enhancing organisational approaches to, and accountability for, candour. However, it is not clear that increasing individual accountability through a new legal duty would in itself deliver or promote the desired improvements in safety outcomes (broadly – positive changes towards open learning cultures where providers are supported to communicate honestly and openly with service users when things go wrong). Therefore, consideration should also be given to wider initiatives to support the desired improvements – for example, tools and support for staff to raise concerns in psychological safety without fear of reprisal.

If a statutory duty were to be placed on NHS leaders, a careful approach would be needed to reduce the risk of inadvertently creating 'grey' areas and/or unnecessary overlaps between individual- and organisational level regulation. Clarity would be required on the precise boundaries and expectations around individual and organisational accountability for candour, and the precise roles of providers and particular individuals – especially given that representatives of registered persons already have responsibilities under the existing statutory duty of candour.

3.9. NHS leaders' duty to respond to safety incidents

A. Question: Do you agree or disagree that individuals in NHS leadership positions should have a statutory duty to record, consider and respond to any concern raised about healthcare being provided, or the way it is being provided?

Question: Do you agree or disagree that individuals in NHS leadership positions should have a statutory duty to ensure that existing processes in place for recording, considering and responding to concerns about healthcare provision are being correctly followed?

The final report of the Infected Bloody Inquiry makes multiple recommendations linked to achieving a safety culture, including that NHS leaders should have a legal duty to record, consider and respond to any concerns raised about healthcare being provided, and that any person in authority to whom such a report is made should be personally accountable for a failure to consider it adequately.

Whilst we have no objection to introducing a statutory duty for NHS leaders which aligns with the report's recommendation, if the Government's overarching aim is to strengthen public protection through improvements in safety culture, then leaders and their teams must also be supported to optimise the effectiveness of processes for

managing safety concerns (e.g., help with the design, evaluation and continuous improvement of processes) and to build environments and cultures which are conducive to operating processes effectively (e.g., support for staff raising concerns or managing or involved in safety incidents).

We consider it much more important to ensure that processes for recording, considering and responding to concerns about healthcare provision are effective, rather than simply followed correctly. Most NHS providers and organisations will already have processes in place to manage concerns, so if the associated safety outcomes are currently suboptimal, then any barriers to raising concerns or managing concerns appropriately are critical to address. This is key to another of the Inquiry report's safety culture recommendations, which is that to avoid a culture of defensiveness, lack of openness, failure to be forthcoming, and being dismissive of concerns, leaders should also be accountable for how safety culture operates in their part of the system, and for the way in which it involves patients.

18 February 2025