General Dental Practitioner Committee Report

5th May 2017

Summary:

- In a deal negotiate with the LMC/GPC, NHS England are now reimbursing all doctors the percentage increase in their professional indemnity insurance, for this year and all subsequent years. This is felt to be good news at it is likely to focus the government's attention in handling the claims culture, as they will, personally, be picking up the tab for its effects.
- Opticians are currently being targeted by the HMRC on their employment status. The majority work as locums on a self-employed basis.
- The GDPC triennial term will be coming to an end in Dec 2017, with nominations/elections taking place using a new electronic (website based) voting system.
- Keith Percival (Hampshire LDC) has been re-elected to stand for the British Dental Guild again.
- DDRB has recommended a 1% increase in dentists pay. Although not official until after being signed off by the new government, following June's election. It is expected to be passed in late June resulting in a contract uplift of about 1.2% in August's schedule (back dated to 1st April 2017)
- The orthodontic tendering process has stalled due to the government election status and the BDA legal challenge is likely to roll into a judicial review of the process. The theory is that the tendering process can continue throughout all this but the general consensus is that deadline for the procurement will be delayed by 6 months or more likely, a year.
- The BDA are still consulting on whether compensation can be claimed, as a good will payment, if a performer or provider is quantifiably out of pocket due to the Capita delays in allocating performers to new contracts. It is thought that claims could be made through the ombudsman and likely amounts are £2000 per month. If a provider accepts an NHS England offer of a rollover of UDAs into a following contract year, this is likely to be seen as an equivalent good-will resolve, however.
- Breach notices to be made time limited (with a bit of luck)
- Urgent care is being reviewed in general. NHS 111 is being looked at and although it is designed to be extremely risk averse, it is possible for dental issues to be diverted earlier to dental nurse advisors.
- A confidential contract reform report has been released with views on the prototype progress. You don't have sufficient security clearance to be informed of what it says, as details are on a need to know basis.
- Amalgam phase down has now been ratified. From 1st July 2018 amalgam should not be used in the under 15yr olds, pregnant or breastfeeding women (except when deemed strictly necessary by the dental practitioner based on the specific medical needs of the patient. All other precautions are already in place; amalgam separators in suction systems and use of capsulated amalgam.
- Regional liaison group meeting conclusion confirmed that any referral for OPGs/DPTs taken in NHS hospitals cannot be charged for privately to either a patient or dental practitioner as this breaks the terms of the "free at the point of service" mantra of the NHS. The NHS/trusts

will pay all costs. Any cases of charging are to be reported to Carol Reese (via Tom King at the BDA).

- The conference after dinner speaker with be Kevin Lewis (ex-Dental Protection)

The LMC and GPC having been very proactive is negotiating a reduction in the expenses of doctors. The well-publicised shortage of GPs has assisted with this. As part of this deal, they have won a reimbursement of the “percentage increase” of their indemnity insurance for this year and then each subsequent year. The doctors pay about double what we do and their percentage increase in physical money terms is big. They are also getting their entire CQC annual registration fee reimbursed. Although dentists are not being invited to negotiate similar deals, the effect of this offer will be felt in government addressing the “claim culture” we are experiencing. It is felt that as they will now be paying for the effect of the claims against doctors in their increased premiums, they will be actively addressing the no win- no fee claims and the disproportionate legal fees associated.

Although there is no pressure on dentists over their employment status, it is a constant threat. Since the Pimlico plumbers and Uber legal cases, there is becoming more and more concern over the definition of a dentist. Some cases are brought by performers to gain paid holiday rights and although cases are won on a case by case basis, there has been no precedent set. The BDA associate contract retains the right for dentist to substitute their working day with a locum and thus makes the case for self-employed flexibility. However many of the corporate associate agreements are too similar to employment contracts. Now the HMRC is starting to look into the employment status of opticians. Their self-employed status on the basis of working as locums, often within only one company. Any outcome placing them as workers or employees may well roll into investigation of dentists.

The end of the GDPC terms is coming up. Elections for the 3 Surrey/Sussex representatives will be taking place at the end of the year. This time it will be undertaken using a log-in to a website, in which voters will be emailed a reference number to allow them to vote. The BDA will be emailing all members and the 9000 non-members that they have on their data base. They will also be publicising the elections and encouraging all LDCs to highlight them too.

The DDRB have published their report with recommendation for the 1% uplift for dentists in contract year 2017/18. It is a 226 page document and is available to anyone who wants to read it by dropping me a line. In effect the uplift will be linked to the consumer prices index (CPI) and will mean a 1.2% contract value increase. It is likely to be in the August schedule and be back dated to April 2017. However, this all still needs signing off by the health secretary, whoever that maybe after June. The GDPC will be publishing a recommendation that all providers pass on this uplift to their performers, as is the intention of the DDRB.

The details of the orthodontic tendering process and legal challenge have moved on little more than we already knew. There is a general expectation that the date of the procurement will be pushed back 6 or 12 months but there is no official position. Due to the election process all ministerial responses to legal challenge have stopped but the work being undertaken by both NHS England and the BDA continue behind the scenes.

The BDA are awaiting clarity as to the potential process of compensation for performers and providers that have been left out of pocket due to the failures at Capita over the national performer list. There is the possibility of “good will payments” being made available where a financial loss can be proven. However, it is thought that any application for this good-will may have to be through the

health ombudsman and they are not sure whether they have the authority to grant this yet. The sums are considered to be around £2000 per month, in which a performer or provider was out of pocket. NHS England have circulated claims for rolling over of UDAs form 2016/2017 into 2017/2018, although this is only applicable to providers, a word of caution is that acceptance of this offer may likely mean that any "good will payments" are not applicable as you have be rewarded by this roll over. As soon as the BDA have a clear understanding of the situation they will be publishing guidance for this.

The BDA and NHS England are negotiating over variations in the terms for the use of breach notices, to allow them to be time limited. It appears that there is an active dialogue and a general acceptance that it would be quite reasonable for this to be the case. Especially where the breach is given purely for under-delivery of UDAs. Once a conclusion has been reached the BDA will be publishing guidance and the new terms will be added to the "dental handbook" which all regional team commissioners refer.

Urgent care is being re-evaluated. The hope is that NHS111 can be used to divert dental calls to dentally trained nurses to give dental advice and guidance. At the moment all NHS 111 call handers just process calls through the proformas and they are unable to give any advice. This means that patients are just directed at the end of the call, which has sometimes taken a considerable amount of time. The NHS 111 is extremely risk adverse and any worries of tooth ache which could be myocardial infarction or dental infection, which could be sepsis dealt with on the basis of extreme caution.

Contract reform is progressing, the recent report will be followed up with an official publicised version in September once all the figures associated with the first year of prototypes are shown. The consensus is that the first two waves of practices (the old pilot practices) have not done well within the prototypes but the third wave (the practices which came from UDAs) have done better. The important aspect of this report is that the prototype model has to be financially achievable. It is all well and good having a desirable oral health model and prevention based treatment, if all the practices that undertake it go bankrupt in the process.

In early March, the European Parliament voted in favour of a gradual phase down in dental amalgam. The Regulation on Mercury is the European Union's (EU) plan for ratifying the Minamata Convention, which is an international treaty that aims to protect the environment from mercury pollution. Dental amalgam makes a small contribution to this pollution, and measures specified by the Regulation are designed to minimise the release of amalgam into the environment as well as phasing down its use gradually over several years.

The measures are, largely, already in place in the UK. From 1 January 2019, dental amalgam must be used only in pre-dosed encapsulated form and amalgam separators will be mandatory. Service standards are specified for separators, whereby those installed from the time when the Regulation comes into force must retain at least 95 per cent of amalgam particles; all separators must comply with this level of efficiency by 1 January 2021. Dentists must ensure that all amalgam waste is handled and collected by an authorised waste management establishment. There is no justification for removing clinically satisfactory amalgam restorations as a precaution, except in those patients diagnosed as having allergic reactions to amalgam constituents. This is a rare situation. The process of removing amalgam restorations temporarily releases mercury vapour.

The Regulation states that, from 1 July 2018, amalgam should not be used in the treatment of children under 15 years of age and in pregnant or breastfeeding women, except when deemed strictly necessary by the dental practitioner based on the specific medical needs of the patient. As there is no reliable evidence for restriction based on adverse health effects of amalgam in these patient groups, we assume that this is intended to formalise the principle of phasing down amalgam use in situations where any intervention should ideally be minimised.

The EU's expert Scientific Committee (SCENIHR) stated in its 2015 report:

“To reduce the use of mercury-added products in line with the intentions of the Minamata Convention (reduction of mercury in the environment) and under the above mentioned precautions, it can be recommended that for the first treatment for primary teeth in children and in pregnant patients, alternative materials to amalgam should be the first choice.”

- Children under 15 years: we surmise that this extension of the recommended restriction on primary (deciduous) teeth is based on the assumption that children tend to have small cavities, for which composite restorations would be appropriate in accordance with a minimally invasive approach. However where there are medical or dental reasons to justify the choice, the practitioner will retain the option to use amalgam.
- Pregnant women: the restriction follows the general precautionary principle of minimising any treatment when possible, as stated by SCENIHR: As with any other medical or pharmaceutical intervention, caution should be exercised when considering the placement of any restorative material in pregnant women. It is not based on any specific evidence of harm caused by amalgam.
- Breastfeeding women: this appears to be an extension of the principle for pregnant women and, again, is not based on any evidence of adverse health effects.

Crucially, the wording of the Regulation leaves scope for the dental practitioner to exercise clinical judgement and, based on the informed consent of the patient or their parent/guardian, place an amalgam restoration when this is the most appropriate course of action.

Both the Minamata Convention and the EU Regulation recognise that amalgam is a safe, durable and cost-effective material; the measures are purely for environmental protection and do not reflect any evidence-based concerns about adverse effects of amalgam on human health.

Some patients might raise concerns that the restrictions on use in certain patient groups, as specified by the EU Regulation, suggest that the safety of amalgam is in question. However, the Regulation is based entirely on environmental concerns and there is no evidence-based reason to restrict use in these groups on health grounds. Furthermore, it would be expected that if there had been any perceived health risk associated with the use of amalgam in these groups, the restrictions would have been both immediate (rather than coming into force in July 2018) and more stringent.

The UK dental profession has a longstanding commitment to environmental responsibility and has already implemented many of the measures stipulated by the Regulation. Amalgam remains one of the range of restorative materials available to dentists, to enable them to provide the most appropriate treatment for the individual needs of each patient.

It is not yet clear how the UK exiting the EU will affect the transposition of the EU Regulation into UK law, or its retention in UK law if transposed this year as expected. However, we predict that the ban on import of mercury into Europe will lead to reduced availability and increased cost of amalgam, which could have significant implications for its future use.

The Minamata Convention recognises the need for further development and optimisation of alternative restorative materials, in addition to a greater focus on the prevention of dental disease, as essential steps towards an eventual phase out of amalgam. The EU Regulation requires Member States to set out a national plan, by 1 July 2019, outlining intended measures to reduce amalgam use. A study will be commissioned to assess the feasibility of phasing out dental amalgam in the EU in the longer term, and preferably by 2030; this will report in 2020. Ensuing plans for a phase out will respect the right of Member States to determine the organisation and delivery of their own health services and medical care.

The BDA has worked intensively with national and international partners over the last ten years to move the debate away from an unworkable and immediate blanket ban towards a gradual reduction in the use of dental amalgam. We remain in close contact with the Department for the Environment, Food and Rural Affairs (DEFRA) and the Departments of Health in the UK and are continuing to negotiate through the Council of European Dentists (CED) on a European level, where CED will press for representation in the Commission's work towards the phase out feasibility study. Our domestic work on dental contract reform is ongoing, and we are lobbying hard to ensure that prevention of dental disease is a key focus of NHS dentistry.

There has been a backlash on hospitals that have been charging practitioners and patients for taking OPGs/DPTs. Carol Reese has come on record stating that it is illegal for trusts/hospital to charge private fees for the service and any cases are to be reported to her, to investigate. Any radiographs taken by an NHS hospital is paid for by the NHS.

The BDA have responded to the GDC's document "shifting the balance – a better, fairer system of dental regulation". It is very detailed so I have included it below:

A. Executive summary

1, 2. While the BDA response provides commentary on most issues raised in Shifting the Balance, the key themes for the Association are that:

- The GDC must focus its energy and resources on the remit provided to it in legislation. This is what registration and annual retention fees are paid for, and where the GDC's focus must lie. There are some areas in this document which suggest that the GDC is looking beyond its statutory remit, and registrant monies should not be used to fund these activities.
- In particular, fitness-to-practise continues to be problematic despite some improvement in approach and a better quality assurance system. The BDA's recent regulation survey highlighted this as by far the highest priority issue for the GDC to tackle. The BDA continues to receive highly critical comments about the level of knowledge and expertise of those working on FTP cases, including case workers, case examiners, legal advisers and expert witnesses, including recent as well as historic cases. While the focus on upstreaming and defining 'seriousness' is welcomed, there is still more work to be done to improve the detailed work in the FTP section when cases are handled.
- A reduction of dentists' ARF must be considered by the GDC as a matter of urgency for next year. There is no justification for maintaining the ARF at its current level.
- The focus on upstreaming and first-tier resolution is welcomed. However, support structures for dentists are at risk in the current climate of HEE and NHS spending cuts. The BDA calls

for a formal, independent review of the Dental Complaints Service (DCS) before any consideration is given to extending its remit.

B. Introduction and general comments

3. The BDA is the UK-wide representative organisation for dentists in the UK.

4. We welcome the opportunity to provide comment on Shifting the Balance – a better, fairer system of dental regulation.

5. We have engaged widely with dentists in formulating this response. Between February and April we ran a survey to gauge the opinion of our membership and the wider profession on issues raised in the GDC's document and more generally on issues of dental regulation. We received over 2,000 responses and have also consulted across the BDA's representative structure. This feedback has informed our response. We hope that the GDC recognises the depth and breadth of input to the BDA's submission and attributes due weight to our contribution.

6. Shifting the balance contains a wide variety of issues and action points, with some laudable considerations and a welcome change in approach, tone and language. We remain concerned, however, that some of the proposed and ongoing work requires a lot of investment, all of which is received solely through the annual retention fees (ARF) that registrants pay. 7. We fundamentally believe that the GDC has an obligation to address its failings and concentrate its resources (and registrants' money) on the core aspects of regulation. In the words of the Professional Standards Authority, regulators should ensure that their contribution must remain focused on their core purpose. The content of Shifting the Balance suggests that once again, the GDC is inclined to broaden its reach beyond what is absolutely necessary for the fulfilment of its statutory obligations. The profession certainly shares the PSA's view, with dentists overwhelmingly indicating that getting Fitness to Practise processes right should be the Council's number one priority. The PSA has again identified continuing failings in this area.

8. In relation to the point about sticking to core purpose, one of the GDC's fundamental obligations is to maintain public confidence in dental services. There is repeated evidence that dentists maintain high professional standards and high levels of public confidence and satisfaction. However, we rarely hear the GDC, and its Chair in particular, choosing to emphasise this quality and trust. A more balanced approach would be welcomed and could in turn help to restore a degree of professional confidence in the regulator.

9. One of the issues that Shifting the Balance does not address is the changing expectation of the dental profession from regulators, contractors, the public and patients. Dentists are under pressure from all parties to maintain standards and deliver high quality of care within constrained resources. In the vast majority of cases, the profession meets or exceeds expectation. However, these expectations are becoming increasingly challenging. The BDA believes that there is a fundamental problem around a lack of definition in terms of what is expected of a dentist. What do we expect of a dental student? What do we expect of a graduate? And what does the NHS in particular expect a dentist to deliver? The BDA calls for a fundamental re-evaluation so that we can all be clear about the standards against which we are judging the profession.

10. We realise that investment became necessary to address the failings in GDC leadership in recent years and to design and develop processes to rectify existing problems. The Annual Retention Fee (ARF) was raised in 2014 (for 2015) specifically on the basis of anticipated complaint levels and Fitness to Practise (FTP) action in 2015 and 2016. As the information on page 51 of the document

shows, these projections have not materialised. The GDC should therefore reduce the ARF for dentists for 2018. Our survey of the profession demonstrated clear support for a reduction in the ARF given that complaint levels have not increased in line with projections (88% of respondents supporting a reduction). As the GDC is aware from previous BDA statements, we do not regard the Council's current reserves policy as acceptable or a reasonable justification for the continued high fee level1. We welcome the proposal for a future consultation on the setting of the ARF, but would wish to see a clear commitment from the GDC to a significant reduction of the fee. Furthermore, we would like to see consideration given to the possibility of paying the ARF by instalments. We know from our recent survey of dentists that such a move would be welcomed by the profession.

11. Our survey, developed in anticipation of a Department of Health consultation on major regulatory change (still to be published), showed continuing support for the retention of a dental-specific regulator, but not at any cost. Dentists hold a pragmatic view on the future of regulation, with around two thirds preferring a dental regulator but a similar proportion supporting regulatory amalgamation if efficiencies could be achieved. The ARF debacle has hit the reputation of the GDC hard and the Council is on borrowed time in the eyes of the profession.

12. Support for dental regulation comes with conditions, including overwhelming support for the Chair of any dental regulatory body being a dentist (over 94% of respondents to our survey). The BDA's long-standing policy on this point is clear and well-documented. Confidence of professionals in the GDC's ability to deliver on its reform agenda remains low, with 87% of respondents to our survey neither 'confident' nor very confident' in the Council.

13. Finally, in terms of general comment, we would like to put on record our serious concern for future support mechanisms in dentistry, in particular given likely significant spending cuts at Health Education England. We are aware that support services for continuing professional development and for dentists in difficulty are under threat. Such external factors could seriously jeopardise some of the GDC's proposals contained in this document.

C. Specific comments

14. Below are specific comments on the GDC's proposals for action as they appear in the document.

Section 1: Moving upstream Improving our engagement with professionals Proposal for action: GDC to work with partners, including systems regulators and the NHS in the four nations of the UK, as well as other professional healthcare regulators and the profession itself to develop a data and intelligence strategy, to enable upstream regulation to be intelligence-led by sharing learning with the professions. 15. This is one of the most important areas in this document. The GDC should already have the data necessary to enable learning from complaints over many years, and we were under the impression that data collection and interpretation to identify FTP themes had in any case been undertaken recently. There is a need to ensure that the strategy underpinning the 'upstream' principles works properly; clarity about 'seriousness' and a move away from the 'climate of fear' while registrants agree to take forward considerations of how they might address minor issues that have been raised.

16. One issue that came through very clearly in the BDA survey was that a large proportion of the profession now practises 'defensive dentistry', an approach where they may provide only limited treatments, where they can guarantee a successful outcome, and refer even minor cases where they feel the risk of the possible treatment options is too high. Those who have experience of the FTP process note that their confidence has reduced as a direct result, and most cite stress and depression as results of the experience even in cases where no or minor sanctions were applied.

None of this can be in the interest of patients and also not in the interest of a profession that, by definition, relies on scientific evidence to do the best for the patients it serves and is keen on developing new skills. The current situation stifles innovation, and much of this approach can be traced back to the 'climate of fear' over which the GDC has presided in recent years. It might take many years to encourage a profession that has felt hounded by its regulator to change its approach to practice.

17. The GDC is asked to note the practising arrangements in other parts of the UK, not just England. For example, a recent stakeholder event in Northern Ireland indicated that more GDC interest in the dental systems in that part of the UK would be welcome.

Proposal for action: Building on the work we have done on student engagement, GDC to develop a registrant engagement strategy, making effective use of digital channels, to better meet the needs of registrants and students.

18. It is important for the regulator to keep in touch with registrants and students, and there are some signs from our survey to suggest that the current strategy is working. Students who have been made aware of the GDC's reputation, and are fearful of their transition into practice, have reported that they have been encouraged by GDC communications and presentations in recent times.

19. We would, however, say that there is more work to be done. The old website was relatively difficult to navigate; however, the new one is not overly user-friendly either. Sign-ups to newsletters have not worked for some time, press releases do not seem to be sent out consistently. There is a real need to improve timely information provision, and given that investment has already happened, we would expect to see improvements in this area soon.

Proposal for action: GDC to develop, as part of its engagement strategy, an annual 'state of the nation' report on dentistry. 20. We welcome the GDC's recognition that there is a need to provide a summary and analysis of the complaints it has received each year. However, returning to the core function theme, some of the suggested content of this annual report is outside the remit of the GDC. We would not support the use of registrants' money for work which is done better in other areas of the profession. A statistical analysis does not need to be a large, standalone, and expensively designed 'state of the nation' report but could simply be included in the annual report together with relevant registration statistics. What is important is that the GDC itself takes heed of current issues in dentistry and how they affect the ability of its registrants to comply with regulatory requirements and standards.

21. There is a need for the GDC to be a learning organisation, and this is best done by listening to the profession and its organisations that deal with relevant issues, questions and concerns every day. The dental profession will already be aware of ongoing issues through their day-to-day work and the information they receive from many sources, and does not need the GDC to present its own state of the nation summary. That this suggestion is a low priority for the profession was confirmed by the BDA's own survey.

Proposal for action: GDC to work in partnership with relevant bodies to develop methods of linking the standards to performance management and appraisal. 22. The GDC should not play any active role at all in the performance management of registrants. The 'enhanced CPD' scheme should enable the profession to design ways to use the standards and embed them in its learning. As the majority of dentists, and a fair number of DCPs, are self-employed or even practice owners, appraisal as it is currently known, and presumably understood by the GDC, does not work for large parts of the profession. We cannot support this proposal for action as this is again outside the GDC's remit.

23. The BDA believes that the terminology should change in this area, away from 'appraisal' and 'performance management' and towards a more supportive nomenclature around 'self-directed learning' and 'peer review'.

24. We note the comment that dental bodies corporate could provide a useful opportunity for embedding the standards within practice, particularly in relation to 'harmonising performance management systems and appraisal linked to the standards'. While it is certainly true that some corporates have developed excellent processes to support those who work for them, there is also significant criticism of the working and learning environment within some corporates, often linked to consistency of staffing, restrictive policies on clinical freedom, and restrictions on independent professional support that dentists working in such businesses can access.

25. Corporate bodies are major businesses whose strategies, more than anything else, are geared towards delivering profit. This is not intended as a criticism but a statement of fact. It is relevant to note that 17 registered individuals in four corporates effectively are ultimately responsible for the care of over 6 million patients, generating a turnover of nearly £1billion and having direct influence over the clinical environment of over 4,000 dentists. We believe that the GDC has an obligation to look carefully at the regulation of corporate dentistry directly and assess working practices, before suggesting that their ideas of performance management might be beneficial for the wider profession.

26. For information, GDPs in Northern Ireland have had a terms of service requirement since October 2001 that every dentist should have a practice based quality assurance system. The requirement is that each dentist should participate in a programme of 15 hours of clinical audit or peer review over a three year period. Similar arrangements existed in all four countries but devolved administrations have changed the streamlined systems into different directions over time.

Proposal for action: Based on what we learn from working with the profession to embed the standards, GDC to review the Standards for the Dental Team, in line with the established review cycle.

27. It would be helpful to know what the timescales are for the established review cycle. A review of the standards framework is certainly welcome if it is to be based on dialogue with the profession, and the statistical analysis of FTP data. It would have to be a major, long-term project.

Education Proposal for action: GDC to devise a process to ensure that the learning outcomes are agile and responsive, and continue to be based on appropriate evidence.

28. While we agree that this is an important point, we are surprised that this needs to be included in a document of this nature – it is the core business of the GDC to work with universities and other educators to ensure that pre-registration education is fit for purpose. Changes to the GDC's constitution combined with the lack of a GDC Education Committee may have made this process more difficult, so the input of stakeholders here will be important.

29. The move to learning outcomes alone has brought with it certain risks of lack of calibration across dental schools. At the same time, improvements in the oral health of the population might mean that practical experience of certain treatments is difficult to obtain for some students.

Proposal for action: GDC to develop and adopt a risk-based quality assurance process for dental education, to be implemented in 2018-19.

30. We cannot comment on this proposal until a more defined way forward is outlined; there is little in the discussion document about the detail of what such a process would look like in comparison to the current one.

Proposal for action: GDC to develop materials for registrants who have trained outside the UK to ease their transition into practising here.

31. We do not believe that this is necessarily the role of the General Dental Council. It would be much more useful if registrants from abroad were encouraged by the GDC to contact, and join, their professional bodies, where this information and advice is readily available. It is this lack of information, and at a later stage, a lack of encouragement from some dental practices including some corporate bodies, to gain peer support via professional associations that makes it difficult to support those who struggle with the new systems in which they work. The level of membership in the BDA of non-UK qualified dentists for example is relatively low.

32. BDA research in 2016 indicated those overseas dentists who have faced FTP proceedings were more likely to be non-members of the BDA. We would therefore strongly encourage the GDC to highlight the benefits of professional association membership to new registrants so that they have access to existing support structures. There should be little need for the GDC to produce specific, but generic, advice as the professional associations can provide very individual support.

Continuing professional development Proposal for action: GDC to develop a model which encourages and enables professionals and professional bodies to take ownership of CPD planning, development and innovation. 33. We are supportive of this proposal, parts of which are already underway. We would like to remind the GDC of the feedback we have provided over the years of some of the CPD proposals and the areas that we have identified as unworkable2. The professional associations can again provide much of what is necessary here, and indeed the BDA already provides an interactive CPD planner.

34. One of the main issues that feed into this proposal is the development of a personal development plan. The BDA is clear that the GDC must not, under any circumstances, have access to individual PDPs. It would destroy the concept that professionals reflect honestly and formally on their strengths and weaknesses if they then have to show it to a regulatory body. It is also important that lawyers in FTP cases would not be able to request court orders to see such PDPs where they are not willingly provided. Otherwise, the whole process will be undermined and fail. Proposal for action: GDC to explore the development of a quality-based model of CPD, based on professionals determining their development needs and on the GDC highlighting potential areas of focus through available data and evidence.

35. The GDC's main role should be to provide the data and evidence as described earlier; we do not agree that it should be further involved and are not sure what is meant by a 'quality-based' model; maybe a 'reflective approach' might cover more appropriately the points made in the discussion document, as the 'quality-based' model is not really explained in any detail to provide appropriate commentary. A move away from what is a largely tick-box exercise would certainly be welcomed.

36. Shifting the Balance notes (page 27) that the GDC will reduce CPD hours requirements. It also notes that the GMC has no quantitative requirements for doctors and that CPD in its current format has no strong evidence behind its effectiveness. If that is accepted, then the GDC should be reducing the hours requirement more significantly and leaving it to the registrants to decide what is appropriate in accordance with their PDP.

37. As is recognised in the document, the GMC revalidation model is very different from what can be developed for dentistry, due to the funding and support mechanisms available to the medical profession. Nevertheless, the document's text still has a misplaced focus on the role of 'employers' (page 31 first paragraph). Whichever model is developed in conjunction with the profession, there needs to be a move away from the language around 'employers' for the majority of dentists and indeed some self-employed DCPs.

Proposal for action: GDC to incorporate an emphasis on interactive CPD into the developing model, and explore the risks and benefits of this. 38. We agree that a 'blended learning' approach is best and that some CPD, and certain subjects, should only be undertaken in interactive settings. However, we are not sure that the GDC has appropriate expertise to 'incorporate an emphasis' on interactive CPD. CPD based on personal development planning and reflection must be owned by the individual registrant, and it should be for the profession, the professional bodies and other relevant organisations to help with putting the process into practice. In addition, some professionals, particularly if they are working in remote circumstances, might be caught out by a stringent definition of 'interactive' CPD.

39. Professional isolation can be an issue in dentistry, but it must not be forgotten that dentists can be isolated in large practice settings just as much as in single-handed settings. In addition, individuals do have different approaches to learning that suits them. It is much more important to make clear that the responsibility lies with the individual professional to reflect on their strengths and weaknesses in a safe and supportive process than to prescribe set methods of learning.

Proposal for action: GDC to incorporate a significant peer review element into the developing model, and explore the risks and benefits of this. 40. We agree with the sentiment of this and much of current thinking goes in this direction. While the profession will find ways to support this, it is important to note that the system in medicine, which is so often cited as an example, is largely funded by the government, while dentists have little access to such funding.

41. Whilst we would agree with peer review being a significant element of professional development, Shifting the Balance also say (page 33) that the GDC is "exploring ways in which CPD courses could be accredited in order to improve quality". Again, this is not within the GDC's remit and the Council should not be getting involved in this activity. CPD providers already have quality assurance measures which they review and refine over time as necessary.

42. In addition, in England specifically, the deanery structures are currently being changed, with provision of CPD and other support services through HEE appearing to be withdrawn or, at best, significantly curtailed. While the new structures and funding mechanisms are unclear, it will not be possible to design a formal system that has the support of the profession, and there may be a need to delay this work until the new structures are much better understood, and it can be clarified how the services that are being cut can be picked up, and by whom. 43. The response to our survey showed that 67% of registrants who had participated in peer review projects had considered this a 'good' or 'excellent' experience when professionally organised. 44. The survey also showed that 60% of registrants already use a personal development plan and that 44% of those rate its use as 'good' or 'excellent'.

45. Whilst gaining new skills should generally count towards a professional's CPD, it is also important that updating existing skills on the basis of new scientific evidence, and identifying weaknesses in one's existing practice and addressing them, should be recognised as an important aspect of CPD which must not be forgotten.

First-tier complaints resolution Proposal for action: GDC to develop tailored welcome packs for each of the individual registrant groups which include information and advice on the standards, guidance and sources of useful information, which could include the principles of good customer service and complaints handling. 46. Certainly the GDC should provide some of the information, but again a reference to the various professional bodies and the support they can provide would be welcome. There is no need significantly to extend the GDC's information materials in this direction if it is available elsewhere. The information that the GDC alone holds, however, should be shared widely and helpfully should include case studies.

47. Producing guidance on the "principles of good customer service and complaints handling" is not the remit of a regulator. This is upstream work that other organisations should be tasked to do and as we have emphasised elsewhere, the GDC should be concentrating on Fitness to Practise. On page 8 the document talks about regulation extending into more formal powers around "standards, codes of practice accreditation". Again, regulation should only be about setting professional and ethical standards which are then used to assess a registrant's fitness to practise. Anything beyond that is not right touch regulation.

Proposal for action: GDC to continue to develop a profession-wide complaints handling initiative to strengthen first-tier complaint resolution. 48. The emphasis on early complaint resolution is welcomed, and we hope to see this taken forward as part of the ongoing work of the Regulation of Dental Services Programme Board. The GDC should be taking steps to encourage patients to complain at the appropriate level, and not encouraging patients to use the GDC as the first port of call. Proposal for action: Work with the profession and partners to promote, embed and encourage customer service and complaints handling in all stages of education, training and CPD, and to encourage dental professionals to seek help and advice when appropriate.

49. There is little specific information in the document beyond what is already happening.

Proposal for action: The GDC to explore ways in which it can work with the profession to encourage the use of feedback and complaints for learning and improving services.

50. The data capture and information as discussed in the earlier section of this document would probably suffice as a direct action from the GDC. Organisations such as the indemnity providers and professional organisations could take this forward to use in their courses and materials.

Proposal for action: GDC to review the DCS in 2017, looking at its functions, its remit and how it is promoted. This will be done in consultation with the profession and its representatives.

51. The GDC has often said that feedback to the Dental Complaints Service (DCS) indicates that it is well-liked by patients and professionals alike. We have received reports that this is not necessarily the case, with feedback from the profession indicating some dissatisfaction with the service and a view that its sole remit was to extract compensation for patients rather than support a fair conversation between the parties. There is pressure put upon dentists to settle and reimburse patients to avoid referral to the GDC or having to take time off to attend panel hearings. A quick result does not always mean a fair result.

52. We addressed views about the DCS in our recent survey. The results show that 55 per cent of those who had experience of the DCS rated the experience as 'poor', with 18 per cent rating it as 'fair'; only just under 12 per cent rated it as 'good' and 2.5 per as 'excellent'. This clearly contrasts to the assurances given by the GDC and the DCS.

53. In terms of being able to make a judgement on the performance of the DCS, we are also concerned that, for at least two years running, the DCS has not published annual reports of activities and outcomes.

54. We are therefore calling for a formal, independent review of the work of the DCS before any further steps are taken.

55. We also ask that, after this independent review has taken place, the GDC should move the provision of a DCS-like service away from its portfolio and that the service is run by another provider, particularly if the service expands to consider NHS care. Our survey showed that there is significant support for a move away from the GDC. 39% of respondents wanted LDCs to play a major role in the provision of such a service, which would also support the move of complaints handling to the local level. Only 13% of respondents supported the GDC's continuing role in this area.

Working with partners Proposal for action: Building on work underway, the GDC to explore with commissioners and the profession the potential for effective clinical governance to play a more central role in learning and quality improvement. As part of this we will explore the development of 'indicators of patient protection'.

56. We are concerned about this proposal. The Professional Standards Authority, in its 2015 document 'Rethinking Regulation', clearly stated that:

"In seeking to adjust their focus […], regulators must remember that their concern is not quality improvement, but quality control. The interventions of regulators should have the common purpose of seeking to minimise risk to the public. The aims of regulation and quality improvement are complementary, and regulators should be careful to ensure that their own activities do not constrain innovation, but their own contribution must remain focused on their core purpose."

57. The proposals in this section seem to go against this statement from the PSA. As mentioned earlier, we support the GDC's wish to learn and understand more about the constraints in which dentists and their teams work, in particular when it comes to 'perverse incentives' through the current dental contract. It is important that the GDC looks carefully at all contractual frameworks across the UK, and proposals for contract reform – it is the very clash of what patients want and demand that occurs when it is not possible to deliver this within the NHS. The Council should be looking carefully at how target driven systems distort professional behaviour, since the regulator will ultimately be policing the consequences.

58. Clinical governance, however, does exist in dentistry, albeit through other processes than maybe in medicine. Much of this returns to the fact that the systems in which medical doctors work are supported and subsidised by the government. Contrary to this, dentists pay for most of their activities in this area, both in terms of monetary investment and time. A formal system of clinical governance did exist (in England) until 2006, when it was quietly discontinued. Financial support for CPD and clinical audit and peer review were nominally included in contract values, but in real terms simply discontinued. Since then, dentists have done their best to continue with quality improvements in practice working through initiatives such as BDA Good Practice; in the absence of formal support from government at a time of ever-reducing investment into NHS dentistry, it may sometimes be difficult to demonstrate in a formal way that clinical governance does happen in dental practice.

59. All countries of the UK have robust regulatory inspection frameworks providing independent assurance about the quality of care, challenging poor practice, promoting improvement and safeguarding patients.

60. Again looking outside of England, in Northern Ireland there is legislative requirement setting out that practices must have in place a system to ensure that all dental care provided is of a consistent quality; that there are effective measures of infection control; that systems are in place to ensure that health and safety and radiological requirements are satisfied; and a system to ensure that any GDC requirements in respect of CPD are satisfied.

61. The criticism of clinical governance in dentistry seems to be based on what we believe is a flawed inference (page 47) that the reason fewer complaints get to Fitness to Practise at the GMC is that medicine has a more developed system of clinical governance. There are many reasons for the differences between the professions. For example, the direct financial relationship that exists in dentistry impacts on patient expectation, and the different regulator approaches to case management and triaging in terms of filtering out low level cases is also key.

Proposal for action: GDC to further develop guidance for employers, reflecting the need for the employer to ensure that the Standards for the Dental Team are embedded within a professional's practice. 62. This is supported; we would like to be able to provide feedback. Please also see earlier comments made about the concept of 'employer' in dentistry.

Refocusing fitness to practise

Proposal for action: GDC to improve all our public facing information, both digital and printed and including that hosted by partner organisations where possible, seeking input from key stakeholders where appropriate, to improve clarity, particularly regarding our role.

63. This is supported but as ever we would encourage the GDC to be careful with registrants' money in taking this forward.

Proposal for action: GDC to implement online tools for 'self-filtering' of complaints, in line with other regulators.

64. This is supported in principle. At a recent meeting of the GDC-convened working group, suggestions were made for improvement of the draft system, such as stating at the beginning that complaints should usually be addressed to the practice initially, and clarifying that the GDC was not a complaints body. The use of the word 'complaint' was excessive in the tool and should be revised and reworded. Clarification of the lengthy timescales for GDC cases was also deemed useful.

65. We would expect to be consulted on an updated version of the tool before it goes live. It is in the public interest for the regulator to make sure that the profession and its representatives are directly involved in all of this work.

Proposal for action: GDC to develop and deploy an explanation of impaired fitness to practise that makes a clearer link to patient risk and public confidence in dental services. 66. The formulation of this criterion is unclear when it is seen as a stand-alone proposal. In relation to the accompanying text in the document it becomes clear that this is about defining the concept of 'seriousness' based on the decisions made at FTP committee level. We would support the approach as there is widespread concern about 'gold plating' in relation to expected standards at FTP hearings. We would also ask that the GDC works closely with the indemnity providers in this area.

Proposal for action: GDC to ensure that the emphases in the tests applied at the triage and assessment stages enable the GDC to achieve our statutory objectives of protecting the health, safety and wellbeing of the public, promoting and maintaining public confidence in the regulated professions, and maintaining proper professional standards and conduct for members of those professions. 67. This is directly linked to the previous proposal and we would regard this as the GDC's core role. It is fundamental business and the GDC should be getting this right.

Proposal for action: GDC to review all guidance material for fitness to practise decision makers to ensure that seriousness is properly and fully embedded within it. 68. Again, we would regard this as core business and is a fundamental area if the GDC is to address decision-making at FtP hearings.

69. Many of the cases that have concerned registrants and created a climate of fear amongst the profession are those that do not meet the threshold of being far below the standard and should never have gone beyond Case Examiners or Investigating Committee. A complaint received by the GDC should not be regarded as a potential tip of the iceberg requiring investigation on the basis that it might engage fitness to practise issues in a misguided desire to protect the public. This is particularly the case in single incidents in an otherwise long and unblemished career.

70. There is also the controversial area of regulators "getting involved in matter of public and private morals" (page 8 of Shifting the Balance). The protection of the public and patients is served by concentrating on registrants' interactions with their patients, not their family or friends or the personal views they may share.

71. We would strongly support the GDC's own description on page 55 (and p14) that "impaired fitness to practise implies shortcomings in competence or conduct that are so serious as to put patients at risk or to cause serious damage to broader public confidence in dental services". Only if a sanction of erasure is a real prospect should a case ever get to a full hearing and other sanctions should be used where appropriate.

72. It is in the public interest for the regulator to make sure that the profession and its representatives are directly involved in the development of FtP material and we look forward to working with the GDC on this.

Proposal for action: GDC to carry out an end-to-end review of the fitness to practise process, involving stakeholders and partners. 73. This will be an interesting and important project; the BDA should be involved and actively consulted on this. We would support the notion that the system should be "capable of providing a graduated response, proportionate to the risk" (page 9 of Shifting the Balance). It has appeared in the recent past that a one-size-fits-all approach has been applied to every complaint that passed triage, leading to inappropriate cases ending up at hearings or returned back to Investigating Committees for review of the decision to refer (Rule 8E/10). This is wasteful of resources and creates unnecessary stress for registrants.

Proposal for action: Building on the work of the RDSPB, the existing NHS Concerns process and other initiatives described above, the GDC will work with partners to develop a comprehensive model for the resolution of complaints and concerns about dentistry in each of the four countries of the United Kingdom. 74. This work is of course already underway, and the BDA contributes, as do many other stakeholders. We would ask that, as part of this work, our comments about the dental complaints service are taken into account.

Proposal for action: GDC to establish external calibration mechanisms with partners to ensure that concerns are being referred appropriately between bodies. 75. This is important work so that duplication between regulators is avoided.

The BDA have published their Top Ten member issues, which they are enquired upon:

The most common queries recently have been:

1. Orthodontic procurements including the BDA's legal challenge

2. Extensions to Orthodontic PDS agreements, new clauses and KPIs

3. CAPITA/PCSE issues

4. New business rates requirements and eligibility. A large number of members didn't know they were eligible

5. Year-end performance

6. Buying and selling practices

7. Patient issues such as failures to attend, consent, complaints and data protection

8. What is going to happen to the GDS contract in the future?

9. Who can hold GDS contracts and protection of the contract in the event of death

10. Members experiencing problems contacting local area teams, issues taking a long time to get resolved or there being no resolution. Local area teams seem to be struggling to meet the needs and requirements of providers in terms of staff never being available, not returning calls and things being passed from person to person.

The next meeting is scheduled for 6th October 2017

The minutes of the January meeting are published, I will make them available to anyone who wants them.

Toby Hancock

Sussex and Surrey representative