

# Dental Protection Evidence Submission

Health Select Committee: 2015 accountability hearing with the General Dental Council

March 2015

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## Summary

- 1. We know that patient satisfaction with dental care is high. A 2013 General Dental Council (GDC) patient survey found that 96% of patients that visit their dentistry once a year are satisfied. The professionalism of the dentist is the main driver of patient satisfaction<sup>1</sup>.**
- 2. We believe that the GDC is not performing as it should against some of the five principles of effective regulation, identified by the Better Regulation Executive, and used as the Professional Standards Authorities (PSA) building blocks for the development of ‘Right Touch’ Regulation<sup>2</sup>.**
- 3. More support is needed for professionals to promote accountability amongst themselves and the GDC has an important role encouraging the profession to be accountable, rather than simply focusing on holding them to account.**
- 4. The GDC needs to concentrate its efforts upon more targeted interventions, more proportionate responses and encouraging greater accountability.**
- 5. Good regulation is not necessarily more regulation, nor is the perception of greater levels of regulatory activity an inherently desirable goal. The quality and appropriateness of the regulation, rather than the quantity is undoubtedly preferable. Our concern is that there remains a belief within the GDC that increased regulatory activity – and more visibly robust activity – equates to success.**

## About Dental Protection

- 6. Dental Protection is a member of The Medical Protection Society Limited (MPS) group of companies. Dental health professionals can apply to become dental members of MPS, served by Dental Protection, with access to all the benefits of membership which are set out in MPS’s Memorandum and Articles of Association. These discretionary benefits include professional indemnity, advisory and educational services. Together we protect and support the professional interests of more than 64,000 dental health professionals around the world, including the large majority of UK dentists.**
- 7. MPS is not an insurance company, but a mutual (not-for-profit) organisation which exists to serve and protect its members and to safeguard their professional reputation, interests and integrity.**
- 8. We assist dentists with inquiries by Dental Councils and other Regulators in all of the jurisdictions where we operate. We also have experience of managing claims in negligence worldwide. We are well placed to comment meaningfully on the current hearing.**

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<sup>1</sup> 2013 GDC annual patient and public survey

<sup>2</sup> Right Touch Regulation, August 2010, Council for Healthcare Regulatory Excellence (Professional Standards Authority)

## **Recent developments**

### Section 60 Order – Introduction of Case Examiners

9. Dental Protection broadly welcomes these proposals because we feel that a radical change of approach, and culture change, is needed within GDC fitness to practise procedures. However, in order to ensure that these proposals have the intended impact, the GDC must be committed to taking full advantage of these new powers.
10. While we welcome these changes, we remain concerned about how the statutory test is applied at the early stages of the fitness to practise proceedings. In our experience, those involved in cases do not appear to accurately apply the definition of “misconduct” as used in the Dentists Act 1984 (as Amended 2005).
11. As a result, we fear that too many dentists are made subject of an investigation unnecessarily and without the proper protection offered to registrants in the Dentists Act. Therefore, while the introduction of case examiners should make for more effective case management, unless these other concerns (about how decisions are made) are addressed, we believe there will continue to be problems. We would urge the Committee to explore this point in greater detail with the GDC.

## **The GDC’s approach to regulation**

### Accountability – Encouraging professionalism or relying on regulation?

12. Safeguarding the public and improving patient care is best achieved by promoting professionalism and accountability amongst professionals.
13. One example of this would be a recent advertising campaign, within which the GDC failed to encourage patients to use in-house complaints procedures rather than immediately referring a complaint to the GDC or Dental Complaints Service.
14. The GDC requires every registrant to make such an in-house service available to their patients, and should therefore encourage them to be used effectively.
15. The GDC does not do enough to encourage dental organisations, employers and those that commission dental services to deal with concerns about performance or other issues internally before escalating a complaint/concern to the GDC. All such organisations should have internal procedures to deal with concerns, and it should not be the GDC’s role to replace these mechanisms. We welcome the initiative announced by the GDC in its press release dated 9 January 2015, launching a Pilot Scheme with five NHS Local Area Teams encouraging local resolution of performance concerns. This is a promising start, but it needs to be applied more widely and with a sense of urgency.
16. In the meanwhile, the GDC should make greater use of its existing powers to ask complainants/informants whether they have first tried and exhausted the internal complaints mechanisms of dental practices and organisations, before the GDC refers such cases as potential fitness to practise cases.

## **The GDC's record as a regulator**

### Guidance

17. In September 2013 the GDC's revised guidance Standards for the Dental Team was introduced. At the same time their Scope of Practice guidance was revised. These two guidance documents are clear and concise, striking the right balance between loose high-level principles and overly prescriptive, inflexible detail. This has been a significant improvement on the previous guidance Standards for Dental Professionals. By providing more detail in the guidance, the intention of the GDC is clear, both for patients and dental health professionals.

### Targeted regulation

18. It is our belief, based on our extensive interactions with the GDC on behalf of members, that those handling complaints for the GDC are not applying the correct statutory tests, which means that too many dentists are being investigated, without the proper protection offered to registrants in the Dentists Act.
19. Additionally, there are too many Interim Orders Committee (IOC) hearings involving matters with little or no evidence of risk to public safety, and consequently where no Order is made. This suggests that the incorrect test is being applied to referrals to IOC.
20. In some cases the GDC uses the blunt tool of an IOC referral where cases have not been processed by the GDC in good time. If the case is not serious enough for the GDC to process it quickly and efficiently, it is not likely to be serious enough to merit an IOC referral many weeks or months later.
21. In the 2005 amendment to the Dentists Act 1984, the GDC was given the option to refer dentists to a Professional Performance Committee (PPC) as an alternative to the PCC or Health Committee. The number of PPC referrals in the past eight years has been very small. Between 2010 and 2013, only nine hearings out of a total 578 were Performance cases<sup>3</sup>.
22. The GDC should ensure they are more targeted in their approach to cases by making greater use of PPCs where appropriate. There is a concern that the GDC seeks to identify reasons not to refer a case to the Performance Committee, principally by introducing allegations of dishonesty and/or imputing dishonesty in to innocent actions, often because of an apparent lack of understanding of the dental professional environment. Our view is that to raise an allegation of dishonesty against a professional person is very serious, and the GDC has been misguided in its approach to the assessment of fitness to practice cases at the early stages.
23. The GDC's Balanced Scorecard data published in September 2014 indicates that at that point there were 299 cases waiting for a hearing, of which almost two thirds (64%) had been waiting longer than the target wait of 15 months. Had cases been properly assessed and dealt with according to the Act, it can be assumed that this number could have been considerably less.
24. A more targeted approach may improve efficiencies and the experiences of the practitioner. We must not forget that for a patient raising a concern, a delay of more than 15 months must also be very worrying.
25. We believe that the Committee might wish to explore the lack of use of the Performance Committee, the delays in dealing with referrals and the disproportionate use of dishonesty allegations with the GDC.

### Proportionate response

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<sup>3</sup> GDC Annual Reports and Accounts 2010,2011,2012,and 2013

26. While we recognise, and welcome, that the GDC is running a pilot scheme addressing some of the issues surrounding post-referral case management, it will remain the case that the volume of cases referred to Investigating Committee (IC) by case workers - that are subsequently referred by IC to practise committees and the IOC – is disproportionately high.
27. We are also concerned that too often; the tests that are used in the early stages of a fitness to practise investigation are neither correct nor proportionate.
28. The correct test to be applied to any information received should be firstly to determine:
  - a) Whether or not the information might amount to an allegation of current impairment in fitness to practice of the registrant
  - b) That there is a reasonable prospect of that allegation being proved.
29. For an allegation to reach that threshold the facts have to be capable of being proven on the balance of probabilities, and those facts will have to amount to misconduct, poor performance and/or health issues. The courts have set out what the term 'misconduct' means, as have the Law Commissioners. It is in all material respects no lower a test than the previous test of 'serious professional misconduct', and should amount to disgraceful misconduct. Critically, it is not the same as negligence, although we believe that there is a lack of understanding amongst the fitness to practise team in this regard. In order to represent 'misconduct' any conduct would have to fall far below or seriously below the standard of a reasonable group of registrants.
30. It appears that the present difficulty arises because 'misconduct' is being interpreted as simply below an acceptable standard rather than seriously or far below that standard.
31. In addition, we are concerned that the National Clinical Assessment Service (NCAS) clinical reviewers and other experts used by the GDC do not always properly undertake the 'reasonable practitioner' test.
32. In our experience, we fear they are measuring the standard of the ordinary practitioner against published Faculty of General Dental Practice (FGDP) Standards Guidance for Record Keeping without recognising that this guidance was designed to be aspirational, the 'gold standard', rather than the minimum standard expected of an ordinary practitioner.
33. As far as we are aware, no formal enquiry has ever been made of the publishers of this guidance as to what it purports to represent, and as a result, heads of charge in fitness to practise cases regularly include allegations of a breach of a third party standard for which there is little or no evidence base, and in some instances, which has since been withdrawn or amended. We believe that the GDC has erred in regularly relying upon this and other guidance without questioning the provenance or intention of that guidance.

#### Performance and Independence of the Investigating Committee (IC)

34. We are concerned that the Investigating Committee is not strong enough in taking decisions to close cases with insufficient evidence and also that it lacks the necessary independence. The GDC's own "Hudson" report - which unfortunately has never been published in full - was critical of the way staff interacted with this independent committee. We would urge the Committee to explore with the GDC the reasons behind the commissioning of this report, what the findings were and what steps the GDC is taking to preserve the independence of the IC.

35. The role of the IC is to close any case where the allegations do not meet the 'reasonable prospect' test or will not amount to current impairment. The IC has the option to close the case with advice or a warning, but in many cases where we believe this can and should have happened, the IC either seeks additional records, where they already have sufficient information on which to base allegations, or they agree to decisions before the committee convenes and therefore properly decides on a case.
36. This means that numerous cases are referred for full inquiry which will, after investigation, be referred back for closure prior to a hearing, or, result in a full hearing at which no impairment is found.
37. It is important to note that in the first seven weeks of 2015, the PCC has closed six cases out of a total of 40 that were concluded with a finding of "no misconduct found" whereas it has erased four registrants in the same period. In 2014 it does not appear that any cases were closed with "no misconduct found". If this ratio continues throughout the year, it could suggest that numerous inappropriate cases are being passed on to a hearing by the IC.
38. The current cases are within the backlog of cases referred to by the GDC as justification for the increased Annual Retention Fee. However, in our experience, many of these cases were inappropriately referred, and they should not be subject to the GDC's 2015 Fitness to Practise machinery. In the September 2014 Balanced Scorecard the GDC states that 7% of cases were closed with a finding of no misconduct and/or no current impairment. This compares with 15% in the current year so far, suggesting that too many inappropriate cases may have been referred.

### **Concluding remarks**

39. Dental Protection recognises that the GDC has a challenging remit of regulating not only approximately 40,000 dentists but also more than 60,000 Dental Care Professionals. However, it is crucial for both patients and registrants that the GDC takes the right approach to regulation. In particular, it needs to carefully review how it approaches fitness to practise cases, particularly at the early stages.
40. We are supportive of the reforms that are being introduced to improve the efficiency and accuracy of the fitness to practise process. However it is crucial that the GDC takes advantage of the new tools that the Section 60 Order provides them with.
41. Whilst we are pleased to see that recently the IC has taken a more proportionate view of cases, we have seen no long term evidence that these changes are properly embedded. We have seen similar green shoots of improvement on other occasions in the past five years, but they have sadly not been sustained.
42. We recognise that Dental Protection has an important role here. For our part in assisting, supporting and representing dentists and dental care practitioners, we will encourage respondents to fitness to practise investigations to address any weaknesses identified at the earliest stages, so that patient care improves.
43. We support the concept of revalidation/continuing professional development and look forward to working with the GDC and other stakeholders to develop a valuable and meaningful system which will protect the public effectively.
44. We believe in the dental profession playing an active part in supporting its own regulation in the public interest, which also maintains and supports public confidence and trust in the dental profession. We remain committed to facilitating any change that contributes to this end.

## **About MPS**

MPS is the world's leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 290,000 members around the world, including the majority of the UK dental profession. Our benefits include access to indemnity, expert advice and peace of mind. Highly qualified advisers are on hand to talk through a question or concern at any time.

Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This includes clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, E-learning, clinical risk assessments, publications, conferences, lectures and presentations.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association.