

Modernisation of the GDC's fitness to practise procedures

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Introduction

The General Dental Council (GDC) is the organisation which regulates dental professionals in the United Kingdom. We set the standards of behaviour that we expect all registrants to follow and fitness to practise is the mechanism which enables us to take action when allegations are made that our standards have been breached.

Fitness to practise is the most contentious and high profile of our core regulatory functions as it can result in the removal of registrants from our register. Our fitness to practise procedures are not there to punish our registrants; they are there to protect patients by ensuring that those providing their dental care are fit to do so. They also provide opportunities for our registrants to remediate any issues that may be affecting their fitness to practise.

The way in which we handle our fitness to practise cases has been recently criticised by our regulator the Council for Healthcare Regulatory Excellence (CHRE) as well as by our own internal auditors. The quality of our decision making and case management and the slow speed of disposal of cases are principal areas of concern. In order to address these we have made a large number of operational changes to our FtP processes to improve our performance including:

- an increase in the number of Investigating Committee meetings a month from three to four,
- more initial assessment meetings;
- a reorganisation of the fitness to practise team to increase the administrative support to caseworkers;
- the introduction of a process for handling complaints about the fitness to practise process;
- a better structure for performance management of cases;
- the development of a new protocol to seek health reports for registrants who have a drink driving or drug conviction;
- the introduction of an escalated procedure for gathering information from third parties to reduce delays; and
- the establishment of a compliance team to ensure systems of internal quality assurance are applied to each decision point in the fitness to practise process and to our casework administration;

These changes have resulted in a reduction in the number of cases awaiting an initial decision by the Investigating Committee from 301 at the end of February 2011 to 195 at the end of June 2011. At our Council meeting on 22 September 2011 a further two changes to our operational processes were agreed to improve efficiency; triaging and clinical input prior to consideration of a case by the Investigating Committee.

Whilst these changes will improve efficiency at the start of the fitness to practise process we are still working within the confines of a 'one size fits all' model which means a single incident clinical complaint is managed in the same way as a serious conviction. We do not believe that this is the most efficient way of ensuring the public are protected; it does not observe the principles of right touch regulation championed by the CHRE nor is it fit for purpose for a modern and effective regulator. Increasing the capacity of both the Investigating Committee and the Practice Committees relies on additional resources which is justified in the short term but it is not sustainable in the longer term. To make a real difference to the process and to ensure that our primary focus remains the protection of the public and patients we need to make amendments to both our primary and secondary legislation.

Many of the proposals set out in this document are already being used to great effect by other healthcare regulators and annex A provides information about the activity of those regulators. Our aims for introducing these changes into our own fitness to practise processes are to:

- streamline and improve our processes without detriment to public protection;
- ensure that cases of impaired fitness to practise are dealt with speedily;
- ensure resources are properly focussed on cases of impaired fitness to practise;
- ensure that our systems and processes provide a flexibility of approach tailored according to the seriousness of cases; and
- ensure that our processes are fair and transparent
- more effectively protect patients

We also believe that the proposed changes will enable us to make decisions which are more:

- consistent,
- transparent and accountable,
- proportionate,
- targeted, and
- efficient.

How to respond

The purpose of this document is to seek the views of some of our key stakeholders to assist our Council in deciding whether to request these changes to our legislation. Council will consider these views before beginning the process of drafting and embarking upon a full consultation in early 2012 to ensure that we capture the views of all our stakeholders. The next Council meeting is on 8 December 2011 and so we would be grateful if you could provide us with your views by 15 November 2011. We recognise that this is a short timescale but as you are no doubt aware, amending legislation takes time and we want to request any changes at the earliest possible opportunity. We are happy to meet with you to talk through our proposals in more detail if that would be helpful.

To submit your formal response to our proposals please contact:

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Our fitness to practise procedures

Current process

Our fitness to practise procedures are clearly laid out in primary legislation in the Dentists Act 1984 (as amended) and the accompanying rules; The General Dental Council (Fitness to Practise) Rules Order of Council 2006. They provide three key decision points in the process:

Assessment meeting

Where caseworkers make a decision about whether information received could amount to an allegation that a registrant's fitness to practise may be impaired.

Investigating Committee

Where the independently appointed members consider the cases referred to it from assessment meetings. If there is a realistic prospect (the 'realistic prospect' test) of proving impairment of fitness to practise, the case is referred to a Practice Committee. If there is no realistic prospect, the Investigating Committee can direct that the case be closed with either no further action, or with the issuing of a letter of advice, a warning or a published warning.

Practice Committee (conduct, health or performance)

Where a final determination is made on a registrant's fitness to practise.

Annex B provides an outline of the above process in diagrammatical form. Our fitness to practise rules were last amended in 2006 and since then our registrant base has doubled. We have also seen a 76% increase in the number of complaints received about registrants. This has meant that the number of Investigating Committee meetings has risen from one a month to four and the number of hearing days scheduled has increased from 196 in 2006 to 565 in 2010 with plans to run five concurrent hearings in 2012.

According to our current key performance indicators, cases take approximately six months to reach their first Investigating Committee and each case costs the GDC around £1500 (based on the costs of holding the Investigating Committee and the cost of staff resource required to prepare a case for the Committee). This is an unsatisfactory position for all of the parties involved as it means that registrants are in our fitness to practise processes for longer than is necessary, particularly if their case is relatively low level, and it also means that complainants are waiting for a decision on their case for an unacceptable amount of time. It is also an inefficient use of our resources.

Proposals for change

We are proposing to introduce a variety of amendments which we hope will benefit all parties involved in the fitness to practise process as it will enable the investigation process to be more effective and efficient. It is also hoped that these changes will reduce the workload of the Investigating Committee and improve the pace of throughput of cases in the system.

Case adjudicators

We want to introduce case adjudicators to the fitness to practise process following an initial assessment of a case by caseworkers. At present the only mechanism by which we can issue advice and warning letters for the less serious breaches of our standards is through the Investigating Committee. Our proposal is that cases will be considered by two case adjudicators, one lay and one clinical. We expect that these case adjudicators will be employed on a part time basis to allow them to maintain their professional practice (for the clinical adjudicators) or their wider experience and expertise (for the lay adjudicators). The case adjudicators will have a statutory role in the decision making process and so no members of the fitness to practise team, or any other GDC staff member (including the Registrar) will be able to overturn their decisions.

Question one – Do you agree that we should introduce case adjudicators? (Where possible, please provide us with reasons for your answer)

If the case adjudicators are unable to agree on the appropriate disposal of a case then it will be referred to the Investigating Committee. Case adjudicators would also have the power to refer cases to the Investigating Committee where the cases are particularly complex or novel and over time, as the case adjudicators build up their experience and a bank of decisions, we predict that referrals to the Investigating Committee will reduce. As with the Investigating Committee, the case adjudicators will have the following powers open to them:

- conclude a case with no further action,
- issue a letter of advice,
- issue a warning letter (and where appropriate direct that the letter be published),
- refer the case to one of Practice Committees,
- request an assessment of health or performance,
- refer cases to the Interim Orders Committee,
- revoke orders made by the Interim Orders Committee (in certain circumstances).

Question two – Do you agree that the case adjudicators should have the same powers as those currently reserved for the Investigating Committee? (Where possible, please provide us with reasons for your answer)

In addition, we are proposing that the case adjudicators be given a power which the Investigating Committee does not have at present; the power to agree and manage undertakings with a registrant. Undertakings could be an agreement to retrain and/or work under close supervision and/or to an action plan agreed by a deanery, employer or others.

Undertakings would only be agreed when case adjudicators are satisfied that they would be a sufficient mechanism to ensure that patients and the public are protected and that they would be an effective way of addressing the concerns about the registrant. The length of the undertakings would be dependent on the circumstances of the case and would be for a maximum period. Once undertakings have been agreed, they would be regularly reviewed and case adjudicators could decide whether to vary the undertakings or remove them where there is no longer any evidence that there are any fitness to practise concerns. If the registrant did not agree to the undertakings proposed by the case adjudicators, or the registrant failed to comply with the undertakings, the adjudicators could then refer the case to a Practice Committee. If, once undertakings were in place and further information was received which suggested more fitness to practise concerns, then the case could be referred to a Practice Committee. It is important to note that undertakings would not be offered where there is a realistic prospect that a Practice Committee might erase a registrant from the register.

Question three – Do you agree that the case adjudicators should be given the powers to agree and monitor undertakings? (Where possible, please provide us with reasons for your answer)

We recognise that both patients and registrants may have concerns about the introduction of case adjudicators because it would mean that decisions on cases are made by two individuals rather than a fully quorate Investigating Committee. However, we believe that the ability to refer a case to the Investigating Committee if an agreement on disposal cannot be reached should alleviate those concerns. We also recognise that some stakeholders may be concerned about the quality of their decision making. However, we believe that the introduction of clear criteria for decision making and accompanying guidance as well as the close quality assurance of their decisions by our compliance team will ensure that their decisions are consistent. Case adjudicators will be guided to exercise discretion in their decision making and in cases where there are clear fitness to practise issues they will refer cases to the appropriate Practice Committee. The General Medical Council has operated a similar model with case examiners for several years and it has no evidence that the quality of decision making has reduced.

We believe there to be a variety of benefits in introducing the case adjudicators and these are outlined below:

Increased efficiency

As case adjudicators will be employed on a part time basis by the GDC, they will be readily available to make decisions on cases. This is far more preferable to the current situation whereby, even if a case has all the relevant information needed in order for the Investigating Committee to make a decision, cases are waiting for available slots on the Investigating Committee agendas. Our current key performance indicators are for case to be considered by the Investigating Committee within six months whereas we would envisage that case adjudicators could consider a case within far shorter timescale. This timeframe would obviously be dependent on a number of factors, including the date of receipt of a registrant's observations.

Increased flexibility

The current fitness to practise process forces all cases to follow the same route, regardless of their seriousness which means that minor infringements of our standards which would not meet the realistic prospect test are utilising a disproportionate amount of the Investigating Committee's time.

Better reasoning

The case adjudicators will not be under the same time pressures as the Investigating Committee members and so will be able to provide even more in depth reasons for their decisions. There will be clear guidance drafted for the case adjudicators which will set out the realistic prospect test and when they should be issuing advice or warning letters or referring cases to one of the Practice Committees.

Quality assurance and feedback

Training for the new adjudicators will be provided and we will audit the decisions of the case adjudicators to ensure that they adhere to their decision making guidance. Quality assurance will be a cyclical process, where following an audit of their decisions, improvements will be feedback into the existing processes and guidance.

Increased consistency

There is a large the pool of Investigating Committee members and even though there are four meetings a month, there still remains a risk that inconsistent decisions are being made. We are minimising this risk through the provision of guidance and training. We believe that as there will be a smaller number of people involved in the new process the consistency of decisions will be improved. In addition, the quality assurance processes that we aim to put in place will ensure that the case adjudicators make consistent and reliable decisions which will ensure patient safety.

Adherence to right touch regulation principles

CHRE produced a report in August 2010 which set out a number of principles that regulators should adhere to and we think that two of those are particularly relevant to this proposal. CHRE recommends that regulators should only use regulation when necessary and at present there are a number of cases considered by the Investigating Committee which do breach our standards but would never lead to a finding of impairment by a Practice Committee. These cases could be disposed of at a much earlier stage in the process through the issuing of an advice letter by the case adjudicators which would free up more time for the Investigating Committee to consider more complex cases. Cases relating to single incidents of misleading advertising are a good example of cases which should be disposed of quickly. The introduction of case adjudicators would also adhere to the principle of keeping regulation simple.

Ability to monitor clinical competence

The ability of case adjudicators to agree undertakings with a registrant will provide us with a way of monitoring their competence. As has already been mentioned, the purpose of our fitness to practise procedures is not to punish registrants and we believe that undertakings will be an important mechanism for ensuring those on a registers are given the opportunity to demonstrate to us that they have insight into their failings and are fit to practise.

Agility

A more streamlined process will give us the ability to progress the most serious cases to a Practice Committee quickly and it will also remove an inflexible system where every case has to follow the same route.

Proportionality

At present, if there is any indication that any of our standards may have been breached, the only mechanism we have for dealing with a case to refer it to the Investigating Committee. As has already been mentioned above, this one-size fits all approach is not proportionate and does not enable us to fast track those cases which are more serious in nature.

Question four – Do you have any other concerns about the introduction of case examiners into our fitness to practise procedures?

Power to reopen closed cases

The ability to revisit closed cases is a crucial safeguard to ensure public protection within our fitness to practise processes. When there is a case involving a single patient complaint relating to a clinical error in treatment the right course of action may be for the case adjudicators to close a case with an advice letter. However, if further information were received which raised similar concerns to those raised in the closed case then this could be an indicator of an underlying performance issue which needs to be scrutinised.

We have taken legal advice and our understanding is that in a circumstance such as this we can legitimately revisit previously closed cases. When new information is received it would effectively become a new allegation which would be considered alongside any previous complaints which raised similar issues. We are confident that there is a robust legal argument in favour of revisiting previously closed cases under our current procedures but for the avoidance of doubt we want to include this power in our legislation. The ability to reopen a case would clearly need to be within in a given time frame; which is yet to be decided.

Question five – Do you agree that we should add the power to reopen closed cases to our legislation? (Where possible, please provide us with reasons for your answer)

Questions

Question one

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Question two

Do you agree that the case adjudicators should have the same powers as those currently reserved for the Investigating Committee? (Where possible, please provide us with reasons for your answer)

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Annex A – Benchmarking

General Chiropractic Council (GCC)

The GCC is concerned the lack of proportionality in its FtP procedures as the only decision open to the IC if it believes there is a case to answer is to refer the matter to the PCC. The GCC has asked the Department of Health (England) to alter its legislation to enable it to extend the powers of the IC. This request was supported by CHRE as it would help the GCC ‘to manage cases in a more cost-effective and proportionate manner’.

The GCC has also attempted to address concerns about the transparency, timeliness and cost-effectiveness of the procedures of the PCC through proposals for significant amendments to its procedural rules.

The General Optical Council (GOC)

The GOC has recently consulted on and approved changes to its FtP rules which include the introduction of case examiners. The GOC has also been commended by the CHRE for its operational plans to help reduce the overall time taken to deal with FtP cases. It aims to close simple cases within three months, standard cases in six months and complex cases in nine months.

The General Medical Council (GMC)

The GMC already has case examiners and the ability to agree undertaking and this year it has consulted on a variety of changes to its FtP procedures, including four main changes to the way it deals with cases at the end of the investigation stage:

- i. encouragement of doctors to accept proposed sanctions in all cases without referral to a public hearing
- ii. introduction of greater discussions with doctors including in some cases meeting with them before the end of the investigation stage
- iii. introduction of a presumption of erasure for some criminal convictions which are incompatible with being a doctor
- iv. introduction of automatic suspensions for doctors who refuse to engage with the fitness to practise process

The General Osteopathic Council (GOsC)

The GOsC is seeking to change its interim suspension process with a Section 60 order.

The General Pharmaceutical Council (GPhC)

The GPhC applied 'legacy criteria' to the 589 'open' cases¹ transferred to it when it assumed responsibility for the regulation of pharmacy professionals and premises. It was empowered to assess and close these cases under particular criteria - for example, cases could be closed if there was insufficient evidence to proceed.

The oversight and scrutiny mechanisms introduced to manage any potential public perception that the 'legacy criteria' could have been misused to inappropriately reduce the caseload provide useful guidance, particularly as they were supported by the CHRE, for similar internal audit mechanisms that we might introduce.

The GPhC has also developed threshold criteria to be used to screen out allegations that do not give rise to risks to patients/the public, to professional standards or to public confidence in the profession.

The Health Professions Council (HPC)

The HPC is considering alternative mechanisms for resolving disputes and its FtP committee will consider the outcomes of commissioned research in October 2011. It is anticipated that a pilot of these proposals will take place in October 2012 alongside its existing FtP process.

The Nursing and Midwifery Council (NMC)

The NMC is liaising with the Department of Health (England) on two proposed changes to its legislation:

- i. empowering the registrar to refer cases directly to an interim order hearing (rather than through the IC)
- ii. offering registrants the option to apply for voluntary erasure from their register during the course of an investigation.

The Pharmaceutical Society of Northern Ireland (PSNI)

The PSNI has had a number of difficulties with its FtP legislation; as it has not had the power to impose interim orders, nor did it have powers to impose the full range of FtP sanctions.

Legislation published in March 2011 will bring the PSNI's FtP procedures in line with the other healthcare regulators.

¹ Cases either awaiting consideration by the IC, awaiting a final FtP hearing, or part-way through a hearing.

Annex B – Map of our current fitness to practise procedures

