



Shifting the balance:

a better, fairer system
of dental regulation

**General
Dental
Council**

protecting patients,
regulating the dental team



Good regulation starts ‘upstream’ with communications, engagement and learning; persuasion and influence; leadership, partnership and an expression of common goals

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Chair's foreword

The GDC is seeking to open and stimulate a serious public debate on the future of dental regulation. In the development of the ideas contained here we have engaged extensively with many of the groups and individuals that have a stake in dental regulation: professionals and their representative bodies, patient groups, regulators, educators, policy makers and others. We will continue to build on this engagement over the coming months, ensuring that we reach patients and professionals across the United Kingdom (UK). We want to seek views from everyone with an interest in the regulation of dentistry.

The public expects and depends on safe, effective dental care that puts patients first. We know that is what the overwhelming majority of the dentists and dental care professionals working across the UK aspire to, and succeed in, delivering. They are committed and hard-working professionals in whom the public rightly places its trust.

However, there can be challenges to fulfilling those expectations, for a range of reasons. For example:

- there may be tensions between what the patient needs or wants and what the professional feels able to provide;
- the professional, almost by definition, has access to more information about the costs, risks and benefits of treatment than does the patient; and unlike some other sectors, information that can help patients make informed decisions about their care – for example about the performance of individual practices and practitioners – is not readily available;
- dental treatment carries an element of risk, and sometimes things simply go wrong, which can be particularly distressing if the patient did not have a full enough understanding of the risks before the treatment was provided;
- while thankfully rare, there are circumstances in which individual professionals display shortcomings in conduct and/or competence that are so severe that their remaining in practice poses a risk to patients or to public confidence in dental services.

Professional healthcare regulation, which of course includes the regulation of the dental team, is there to try to address some of these challenges – but this can only be achieved by working with professionals, partners and other stakeholders. Increasingly, however, the system of professional regulation in dentistry is losing the support of those regulated.

We recognise that it is an antiquated system, designed for an era in which the relationship between patients and professionals was very different. Reforms of public services stretching back more than a quarter of a century have, rightly, put the public in the driving seat, whilst developments in technology have equipped and encouraged the public to demand increasingly high standards and to complain when those standards are not met.

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The approach we have taken to deal with complaints, which relies heavily on enforcement after things have gone wrong, has not changed sufficiently to meet the challenges we now face. We have come to the conclusion that our approach is outdated.

The tools that legislation has made available to the GDC acting alone do not provide the proportionate and agile responses that are the hallmarks of a modern regulatory system, and which are necessary to deal with the increasingly wide range of issues brought to our attention.

As a result, despite significant improvement to *processes*, the system often fails to deliver the outcomes that patients want or expect; leads to investigations that take too long and are too stressful; is regarded as overbearing and oppressive by many registrants; and has become expensive.

We need to find a better way.

The principles of good regulation have been established and articulated clearly by others, and I do not need to repeat these here. Since the GDC published *Patients, Professionals, Partners, Performance*¹ a year ago, we have spent considerable time listening and developing our plans for change and have been influenced by the excellent work carried out in England by the Regulation of Dental Services Programme Board.

The proposals for action contained in this paper, which we have developed as a result of that engagement, do not depend on wholesale legislative change – although that would certainly be welcome. They are based on leadership, shared purpose, and partnership – none of which need a change in the law but instead require us all to work collectively towards a shared goal: making dental professional regulation fit for the future.

Not all of the ideas presented for discussion in this document are new, and we are getting on with as much as we can already. But they reflect a growing realisation across the whole sphere of healthcare regulation that too often the systems we operate work against, rather than with us. This is a message reflected in both the Professional Standards Authority's recent publication *Regulation Rethought*¹ and the Department of Health's forthcoming legislative reform proposals.

Changing the system will be challenging, but one thing is certain; we have an opportunity to work together to improve dental regulation in the interests of both patients and professionals. I hope you will join us in seizing it.

Dr William Moyes
Chair
General Dental Council

¹ https://gdcuk.sharepoint.com/sites/public/WebsiteFiles/Patients%20Professionals%20Partners%20Performance_GDC%20road%20map%202016_2019.pdf#search=patients%20partners

Introduction

The proposition set out in the paper is based on a simple hypothesis: the current system of regulation:

- does not deliver clear enough benefits for patients nor give them the confidence that their concerns are being addressed within an appropriate timescale;
- has encountered difficulty in maintaining the support of those regulated because it is often cumbersome and stressful for those subject to enforcement, and does not do enough to promote learning;
- is insufficiently flexible to enable a proportionate and graduated approach, resulting in a reliance on expensive enforcement action.

The GDC wants to shift the balance of activity in dental regulation, making the system better for patients and fairer for dental professionals. Our vision is a collaborative system in which the issue is dealt with in the right place, delivering the right outcomes for patients and the public at the right cost and within an acceptable timeframe. One in which the very broad range of levers held by various parties across the system – regulators, the professions, providers, educators and many others – provides the agile and proportionate regulation that current legislation and processes do not achieve. By working together, we can do an enormous amount, without legislative change, to improve professional regulation in dentistry and to make it better for patients and fairer for professionals.

First, however, we think it is important to be clear about what professional regulation in dentistry is for.

What is dental professional regulation for?

The GDC's overarching objective when exercising its functions (set out in the Dentists Act 1984 and recently updated by the Health and Social Care (Safety and Quality) Act 2015) is 'the protection of the public', which involves the pursuit of the following objectives:

- to protect, promote and maintain the health, safety and well-being of the public;
- to promote and maintain public confidence in the professions regulated [under this Act]; and
- to promote and maintain proper professional standards and conduct for members of those professions.

The objectives of protecting the public and securing public confidence are laudable aims. But what do they actually mean? To answer that question, we need to ask two others: who or what are patients being protected *from* and why is public confidence important?

Public protection

Public protection can be a loaded term. It conjures a sense of immediate and widespread risk, or even danger, which is not generally the case in dental services in the UK. However most healthcare services, including dentistry, involve the patient being in a position of relative disadvantage or indeed vulnerability. Such services rely on the integrity of the practitioner – in terms of both competence and conduct – to avoid harm arising from that disadvantage. A key purpose of regulation is to minimise the impact of these disadvantages on patients.

Such disadvantage or vulnerability can take several forms, including:

- Safe, effective dental treatment requires a high degree of skill, technical ability and expert knowledge. Getting it wrong can cause harm. That is one of the reasons why the training processes for dental professionals are lengthy and why only trained professionals can join the register of those permitted to practise.
- The relationship between the professional and the patient is one of trust: abuses of that trust (e.g. financial) are rare but the relationship is vulnerable to such abuse. That is one of the reasons why regulators set standards of ethics and conduct.
- The professional is an expert: almost by definition he or she has access to information – about effectiveness, risks and costs of different types of treatment – that the patient does not. At the same time, dental professionals operate under circumstances in which they are trying to balance many different factors: the provision of the best service to the patient, the obligations of any NHS contracts that might be in place, the demands of running a business, making a living and so on.

Good regulation in relation to public protection should involve all those concerned – not just the regulator – taking proportionate steps to ensure, as far as possible:

- that patients receive safe treatment from a skilled and competent professional;
- that the trust patients place in the professional is justified and respected; and
- that patients are not disadvantaged by their lack of information (usually by taking steps to provide them with the information they need to make rational choices.)

Public confidence

Why is public confidence important? Oral health is an important part of public health. To secure good oral health, as a society we choose to make dental services available. We take steps to ensure those services are as accessible as they can be within the resources allocated. We encourage people to make use of those services. And we promote good oral health through public information and education campaigns.

Take-up of those services, and of oral public health messages, is influenced by many factors, such as cost and ease of access – matters that go beyond regulation and into the broader policy framework around oral health. But one key factor that can have a major impact on take-up, and which in turn can be influenced by good regulation, is public confidence. High levels of public confidence remove some barriers to take-up; low levels of confidence create them.

Public confidence involves all those concerned – not just the regulator – taking steps to ensure as far as possible that standards of competence and conduct across the dental profession are conducive to public confidence in dental services.

In some ways, this is a development and modernisation of a concept that has long been associated with professional healthcare regulation, which is that the job of the regulator is to safeguard ‘the reputation of the profession’. This has arguably led to regulators getting involved in matters of public and private morals that may not have looked out of place a century ago, but seem increasingly out of step with modern society.

We therefore need to develop a shared understanding of what professionalism means and why it matters. Our proposition is that it matters because serious shortcomings in conduct and competence have the potential to undermine public confidence in dental services. This in turn matters because people are less likely to access services in which they do not have confidence. We think that articulating the role of regulation in this way will help us focus our efforts where they can have most impact.

‘Regulation’ is – or should be – a very broad term

It would not be an overstatement to suggest that in dental regulation, and perhaps in professional healthcare regulation more widely, the concept of ‘regulation’ has become synonymous with ‘enforcement’ – investigations and prosecutions – and in fact, that is where we currently spend most of our time and money. The charge the GDC makes to registrants – the annual retention fee – is driven largely by the volume of fitness to practise cases we pursue. Pursuing those cases can be expensive, slow and stressful for all involved. Much the same can be said of professional regulation in other areas of healthcare, and this is becoming increasingly recognised across the whole field.²

But good regulation should involve a very broad spectrum of tools and mechanisms designed to positively influence behaviour. Proportionate and fair enforcement sits at one end of the spectrum. But good regulation starts ‘upstream’ with communications, engagement and learning; persuasion and influence; leadership, partnership and an expression of common goals. It extends into more formal powers: standards, codes of practice, accreditation and a wide range of analogues in place across many different sectors.

² See, for example, <http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/regulation-rethought.pdf?sfvrsn=10>

The term 'upstream' was popularised in the context of public health policy by the medical sociologist John McKinlay, in a 1974 address to the American Heart Association. Using the analogy of a flowing river, McKinlay criticised physicians and health professionals who are constantly 'rescuing' patients from the river, but never look upstream to see why their patients are falling into the river in the first place. Those health professionals, McKinlay argued, are focused on 'downstream endeavours' – short-term, case-by-case interventions – that neither identify nor address the fundamental and systemic problems that lie upstream. An upstream-focused approach may be more complex, but over the long-term will lead to better outcomes and reduce the need of downstream interventions.

Source: McKinlay, John B. A case for refocusing upstream: The political economy of illness. In Conrad and Kern, 2nd edition, 1986, *The Sociology of Health and Illness: Critical Perspectives*. pp. 484-498

Enforcement is needed when the upstream measures have not been sufficient; and even when enforcement becomes necessary, the system should be capable of providing a graduated response, proportionate to the risk. Problems should be managed using the least intrusive mechanism possible, with the most serious sanctions reserved for the most serious problems. Some of this thinking dates from the principles of good regulation identified by the Better Regulation Executive in 1997 and further developed in 2003³ namely that regulation should be:

- Proportionate – regulators should only intervene when necessary;
- Accountable – regulators must be able to justify their decisions and be subject to scrutiny;
- Consistent – rules and standards must work together and be applied fairly;
- Transparent – regulators should be open and;
- Targeted – regulation should focus on the problem.

In 2009, the House of Commons Regulatory Reform Committee agreed that regulation should also be 'agile and adaptive'⁴ – forward looking and able to adapt to change

Much of this thinking is reflected very clearly in the Professional Standards Authority's (PSA) concepts of 'right-touch regulation'.⁵

3 <http://webarchive.nationalarchives.gov.uk/20100407162704/http://archive.cabinetoffice.gov.uk/brc/upload/assets/www.brc.gov.uk/principlesleaflet.pdf>

4 <http://www.publications.parliament.uk/pa/cm200809/cmselect/cmdereg/329/329i.pdf>

5 Right-touch regulation (Revised) Professional Standards Authority, October 2015

<http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf>

Professional Standards Authority –

Eight elements of right-touch regulation in practice:

1. Identify the problem before the solution
2. Quantify and qualify risks
3. Get as close to the problem as possible
4. Focus on the outcome
5. Use regulation only when necessary
6. Keep it simple
7. Check for unintended consequences
8. Review and respond to change

Source: *Regulation Rethought 2016* – Professional Standards Authority

Critically, good regulation should be focused first and foremost on learning. Many in the profession describe the current system as having generated a ‘climate of fear’, and we recognise that. Deterrence is a component of any regulatory system: but any system that relies exclusively or mostly on deterrence at the cost of learning, support and a strong mutual interest in getting the best outcomes for patients is likely to fail. Our regulatory system should support people in doing the right thing because it is the right thing to do; not solely because they fear the consequences of doing the wrong thing.

The model of professional regulation in dentistry

In dental regulation, the law gives the GDC statutory objectives to protect patients and to promote public confidence. While we are given a wide discretion about the activities we undertake to achieve those objectives, the law also says that there are four things we must do:

- set standards for education;
- maintain a register of dentists and dental care professionals who meet the requirements to be on the register;
- set and promote professional standards;
- investigate allegations of ‘impaired fitness to practise’.

Figure 1: Diagram showing the GDC's statutory functions



An important point to note is that three of these functions: setting standards in education, maintaining a register and setting standards are all preventative or 'upstream' measures. Investigating allegations of impaired fitness to practise takes place when harm, or at least the risk of harm, is believed to have occurred. We propose to shift the focus upstream, in order to reduce the likelihood of harm arising in the first place.

There are also a number of criminal offences in relation to the regulation of dentistry. The GDC protects the public by assessing complaints about illegal practice, notably in relation to tooth whitening, and taking enforcement action (prosecuting) where necessary, including building partnerships with local authorities to help address this problem. While this activity has a cost, it is nonetheless strongly supported by the dentists and their representative professional bodies.

We think that patients could be better served, registrants treated more proportionately and costs potentially reduced if:

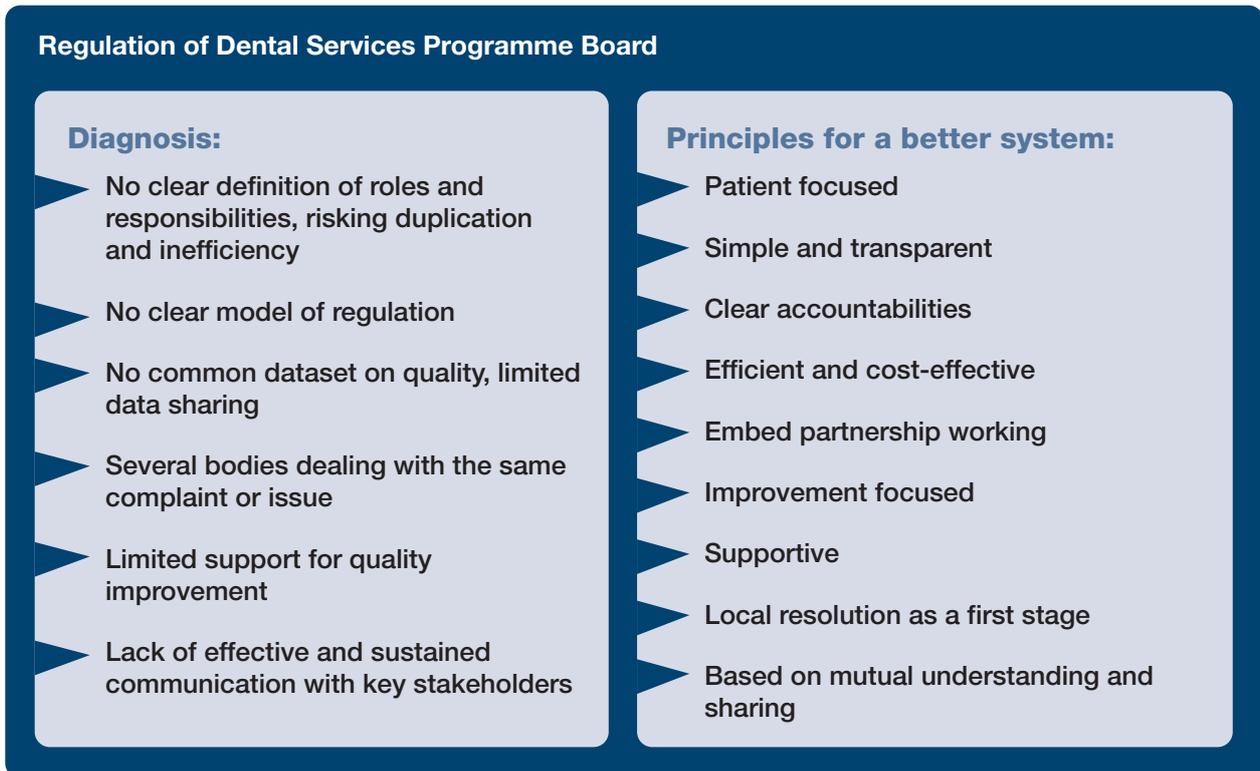
- the focus of effort can be shifted upstream, towards prevention; and
- we can build consensus that good, cost effective, regulation goes beyond the pursuit of the minimum statutory functions and extends into leadership, influence, promotion of positive values, and partnership and collaboration – notably with the profession itself.

Opportunities for partnership and leadership: a complex system

Dental services exist in a very complex system, which poses challenges. Nowhere are they better articulated than in the report of the Regulation of Dental Services Programme Board, published in December 2015⁶ (see figure 2) and we have drawn heavily on those findings.

⁶ The future of dental service regulation; Care Quality Commission, Department of Health, General Dental Council and NHS England, December 2015. https://www.cqc.org.uk/sites/default/files/20151207_future_dental_service_regulation.pdf

Figure 2: Table summarising the findings of the Regulation of Dental Services Programme Board 2015 report on dental regulation

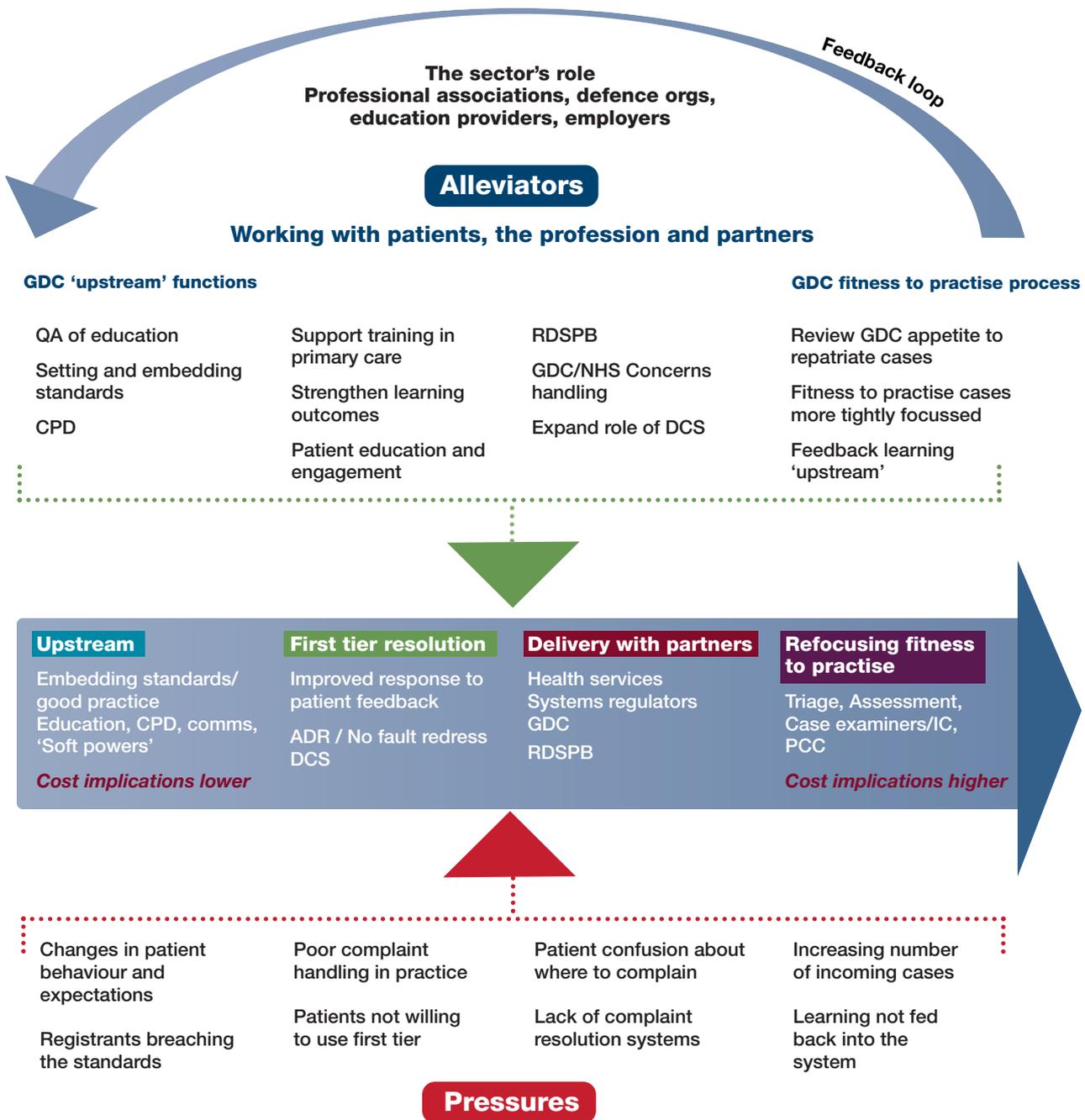


However, that complexity has an upside – with the right leadership and purpose, it offers huge potential for partnership working as the Board itself has already demonstrated in taking forward the various workstreams. One important theme in the ideas we put forward here is that, absent sweeping changes to legislation, if we want a proportionate, flexible and agile regulatory system:

- We need to recognise that the GDC is just one of many organisations with tools to influence both professional and patient behaviour. This is not just regulators or commissioners; it encompasses the profession, peer networks, educators, indemnity providers, dental businesses, the dental media, representative organisations and so on.
- Mechanisms need to be found to join all those parts together so that the right tool is used to deal with the right issue at the right time for the right cost.

Figure 3 provides a visual representation of the various pressures that are brought to bear on the system of dental regulation and some of the ways that they can be alleviated. What is very clear from this diagram is that there are opportunities across the system to ensure professional delivery of services and to shift the balance between prevention and enforcement, with the aim of protecting patients from harm and ensuring that registrants are supported in providing high quality services. What is also clear, however, is that the GDC is reliant on the support and co-operation of the profession and its partners in order to realise this ambition.

Figure 3: Diagram showing the system of regulation, its processes, pressures and alleviators



ADR: Alternative Dispute Resolution
 CPD: Continuous Professional Development
 DCS: Dental Complaints Service
 GDC: General Dental Council
 IC: Investigating Committee
 NHS: National Health Service
 PCC: Professional Conduct Committee
 QA: Quality Assurance
 RDSPB: Regulation of Dental Services Programme Board

So, what should be done? The GDC has been engaging on these issues with patient groups, dental professionals and our partners in dental regulation.

As a result, we have begun to form our proposals for action, which we set out in the following pages – together with work already begun or completed – to move the system forward in the following areas:

- ▶ **Moving upstream:** including putting a stronger emphasis on patient protection, learning within the system, engaging more effectively with registrants and future registrants, and developing alternative approaches to continuing professional development.
- ▶ **First tier complaints resolution:** building better partnerships to improve the handling of patient feedback, concerns and complaints within the practice, and expanding access to mediation and other forms of resolution.
- ▶ **Working with partners:** including other regulators and equivalents and the professions themselves.
- ▶ **Refocusing fitness to practise:** being clear about the serious nature of ‘impaired fitness to practise’ and taking action to ensure that anything short of that is dealt with using alternative tools with the right touch, and providing support to patients to find the best mechanism for resolving their issue.

Much of the territory in this document will need to be part of more detailed ongoing discussion and consultation. For example, the GDC’s current approach to setting fees does not reflect the complex interplay of factors that can affect regulatory cost, does not support effective partnership working and does not encourage all those involved to actively seek opportunities to reduce cost by reducing the need for costly enforcement activity. We intend to consult separately on a new approach to setting fees to reflect a new approach to regulation in the first half of 2017.

This is not a formal consultation document. Much of what we describe we are already pursuing. However, in order to achieve the vision it sets out in full, a very broad consensus between regulators, the profession, policy makers (e.g. the PSA and Health Departments), educators, broader sectoral interests and – critically – patients will need to be built. We want your views, so this document aims to stimulate a public debate on how regulation might be reformed. The proposals for action set out below do not require wholesale legislative change (although more could certainly be achieved with some changes in the law). They do, however, require a fundamental change in mindset and approach and the collective will to make things better for patients and fairer for professionals.

We invite you to consider the content of this document and tell us your views. You can engage with us by:

Providing comments via our online form at www.gdc-uk.org

Emailing shiftingthebalance@gdc-uk.org

Using the hashtag **#shiftingthebalance**

1. Moving upstream

As set out above, regulation is about more than enforcement. Good regulation does not rely on waiting for things to go wrong then taking action after harm has occurred. It focuses effort on reducing the risk of harm occurring in the first place. By shifting the focus of activity towards prevention – ‘upstream’ – the GDC seeks to move to a more supportive model of regulation, based on providing dental professionals with the information and tools they need to meet and maintain high professional standards.

This involves building a career-long learning based system and culture aimed at ensuring that patient protection is at the forefront of everything the profession and the GDC do. This relies on active and positive engagement between the GDC and the profession, to ensure that high standards are maintained, from pre-registration training onwards.

It also relies on us all using the available information and intelligence to inform our activity. For example, for the GDC this might mean developing targeted guidance for employers based on trends in fitness to practise cases, feeding learning back to education providers, or ensuring agility in recommending topics for continuing professional development (CPD). For professionals it might mean ensuring that CPD choices reflect the *Standards for the Dental Team*⁷ as well as being relevant to their practice, or using patient feedback to inform the development of their practice. For the wider system of dental regulation, it might mean ensuring that information is shared appropriately between partners and acted upon in a proportionate way.

In order to do this, we at the GDC need to do more to make information available to professionals. We also need to improve how we engage with professionals more broadly, to ensure that the *Standards for the Dental Team* are embedded into all aspects of practice. This starts with pre-registration education, and continues with the development of new and flexible approaches to CPD.

Building this culture requires commitment and action from all of us. We have developed a suite of ideas and proposed actions to generate discussion about how we might go about doing this in each of these areas. You will see common themes in the proposed activity, particularly in respect of engagement and using information to identify and target specific areas and devise interventions.

⁷ <https://beta.gdc-uk.org/professionals/standards/team>

Identifying learning and putting it to work

Effective upstream regulation relies on using the data and intelligence held by the GDC and others to identify potential problems and to address them quickly and effectively. The benefits of this intelligence-led approach are clear, and many regulatory bodies are now moving towards a risk-based and targeted model, using the available information to determine where to focus their efforts.

We need, as a matter of priority, to improve our collection, analysis and use of data and intelligence, working with our partners and the profession to understand what it tells us. We can then formulate solutions to the emerging problems. The available data we hold of course includes information about fitness to practise cases. We are analysing this data to identify whether there are themes or trends to indicate that particular groups of professionals are having difficulty in meeting the standards. There is scope to do much more and we intend to explore those opportunities.

Our own FtP data is important, but given the relatively small number of professionals⁸ who are subject to FtP proceedings we need to look more widely at the information available when designing interventions that affect the whole profession, and to include data from a range of sources. Such sources could include other professional and systems regulators, the NHS, the profession itself (for example, the corporate dental providers, some of whom have access to significant amounts of complaints data, are of particular potential interest) and those connected with it, for example the indemnity providers.

The work is not without challenges, for example, around patient confidentiality and commercial sensitivity. But if we are serious about developing a regulatory system that is based on learning we will need to find ways to overcome those challenges. We have recently begun work in this area with the CQC, NHS England and the NHS Business Services Authority. We now need to build on this and formalise it in order to be able to develop informed and targeted interventions aimed at the prevention of harm.

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.

⁸ Of the total number of registrants in a given year, only 1.8% enter the fitness to practise process, 0.3% are referred to a practice committee, and 0.2% have a sanction imposed following a hearing.

Improving our engagement with professionals to support high standards

One of the statutory functions of the GDC – the things that by law we must do – is ‘to promote and maintain proper professional standards and conduct’. We produce standards which dental professionals are required to meet in their everyday practice throughout their career and we review, update and re-issue them as necessary. The current edition of the standards, published in 2013 after a thorough review, is *Standards for the Dental Team*.

Currently, each registrant receives a copy of the standards booklet on registration. Yet after issuing them at the point of registration we do not do enough to illustrate what this means for professionals in practice, to support them in meeting and maintaining the standards or check that they are being read, understood and applied.

Part of taking a more collaborative and supportive approach to regulation involves ensuring that every registrant is familiar and comfortable with the expectations placed on them as registered dental professionals. It means encouraging them to develop that familiarity by using innovative ways of bringing the standards to life, and to reach registrants through the appropriate channels. It also means making the best use of the data and intelligence we and our partners hold to identify areas of risk and, therefore, focus for our activity. And there is a very important role for the profession itself to play in taking ownership of embedding the standards.

This starts even before professionals join the register, when they are students, and extends throughout their careers.

Informing the development of our standards

One of the outcomes of our discussions with stakeholders on the propositions set out in this document may be that changes are required to the standards themselves. We will therefore undertake a review of the standards, involving patients, professionals and partners. As part of that review we will consider the purpose of the standards, for example, the extent to which they are designed to encourage good practice and how far they are a standard below which professionals should not fall – and hence how they are used in fitness to practise proceedings.

Models of care are changing, with a shift towards multi-disciplinary teams in many healthcare settings, including dentistry. There is, then, a discussion to be had about common standards of professionalism developed across the healthcare regulators, or at least a jointly-held view of what good care looks like on which similar standards can be based. This could be achieved by building on the work done for *Standards for the Dental Team* which used the expectations of patients as its starting point. We will explore these issues further as part of the development of the next iteration of the standards.

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

The GDC is currently scoping a research project with the General Osteopathic Council, designed to develop our understanding of how standards are applied during a patient consultation. The aim is for this to result in a decision-making framework and tool that can be used by professionals and patients during a consultation. The outcomes of this research will influence our future approach to supporting awareness and understanding of the professional standards.

As described above, we have begun to examine our intelligence and information to understand whether there are themes or patterns in allegations/findings of impaired fitness to practise that registrants could address if provided with the relevant information.

Effective engagement: improving our online presence

Based on what we know about dental professionals' preferred methods of engagement, face-to-face communication and contact is both popular and effective and, as such, should be a key element of our strategy when developing plans to ensure the integration of high standards into practice. There are, however, limits to this, because of the time and resource implications, so we need to be innovative in developing ways of reaping some of the benefits of face-to-face engagement while operating efficiently.

Research over the past few years demonstrates the growing importance of digital channels for dental professionals. The GDC carried out website research in 2015⁹, which showed that 77% of registrants find information about us via our website. While the most common reason for accessing the website was to use eGDC¹⁰, the most popular of the 'other important functions' was 'providing professionals with information about the GDC's standards and guidance.' Recent research with new registrants¹¹ showed that after face-to-face contact, the best way to engage with students is via the website and we can build on this throughout their careers. When we carried out research with registrants¹² about the new standards in 2014, participants told us that the things that would most encourage them to refer to the standards were an app (36%) and interactive content on the website (26%).

What has become clear is that we need to develop and modernise our engagement with professionals, through increased use of digital channels including apps, our web presence and our use of social media. Building on the experience of other regulators, we are currently exploring how we can better exploit these channels in a useful, effective and cost-efficient way, so as to bring maximum benefit for registrants and, ultimately patients.

⁹ <https://gdcuk.sharepoint.com/sites/public/WebsiteFiles/Report%20-%20Dental%20professionals'%20awareness%20of%20the%20GDC%20Standards%20for%20the%20Dental%20Team.pdf#search=standard%20awareness>
¹⁰ <https://beta.gdc-uk.org/professionals/egdc>

¹¹ Survey conducted by the GDC in 2016, with dental professionals who joined the register in 2015 and 2016 unpublished

¹² Dental Professional Awareness of the Standards for the Dental Team, 2014: GDC research library www.gdc-uk.org

This might include filming and uploading and/or streaming at events and the development of webinars on the principles contained in the standards, using case studies and learning points to illustrate what might have led to a different outcome.

We would also seek to link the use of these engagement channels to registrants' CPD activity, in line with the desire to improve the link between CPD and performance/meeting the standards. We would encourage registrants to use these channels with others, enabling peer-to-peer interaction, as well as for individual study.

The General Optical Council (GOC) recently launched their new standards. They published a web video to introduce the new requirements for registrants. These requirements include registrants making a declaration in their online Continuing Education and Training (CET) portfolio that they have read the new standards, as well as completing at least one CET activity relating to the standards for practice per cycle. Registrants need to attain all of the separate standards of competence that underpin both pre-registration education and CET within the three-year cycle.

The GOC approves material and case studies to help registrants understand how the standards relate to the context of optical practice. This material – which can include any topics the GOC particularly wants to draw attention to, including record keeping, care and compassion and safeguarding – is provided on the GOC website.

In line with wider trends in information and content delivery, we intend to increase our digital offering of information and material to support registrants, using a range of methods and channels, including:

- webcasts and/or podcasts featuring interviews with panel members, case examiners and relevant staff;
- webchats involving live question and answer sessions via our website, or hosted by others; and
- online communities and hosted discussion boards.

We also propose to make better use of social media, using it to publicise events and to alert registrants to the publication of new material, including newsletters.

While the development of new channels of communication represents an investment of resources upstream, we would welcome feedback on the usefulness of the various channels described above, as well as new ideas.

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.

Improving content

As noted above, much of what we want to achieve in relation to upstream activity and harm prevention relies on effective use of data and intelligence. We need to make sure that we are using the data and information gathered via our emerging data strategy to enable registrants to make informed decisions about their practice, including their professional development. One aspect of this is the use of case studies on matters that have been dealt with through fitness to practise proceedings which illustrate how breaches of the standards can occur. We aim to use these to develop the content currently available on the Standards in Focus microsite¹³, and use a range of techniques to take web users through scenarios and questions, providing feedback on their responses. We also propose to explore the possibility of sharing case studies across professional and system regulators, as some of the principles are common across all health sector standards and guidance.

We have initial feedback from dental professionals and other regulators suggesting that the use of case studies and scenario based questions is popular and helpful, but we need to ensure that our use of these remains meaningful and keeps pace with developments in practice and technology. We would welcome further observations as to how we can make this work effectively in practice.

While use of digital channels is increasing, there will always be some registrants who are unable to access them, or prefer to access material via other media. We will seek to support these registrants by working with trade and professional journals to develop material that is suitable for publication in other formats, and supplement this with direct communication with registrants (e.g. emails, newsletters).

Identifying issues using the available information

Alongside specific case studies, we will continue to monitor trends in concerns coming to fitness to practise, particularly in relation to those standards which are not being met and the issues causing concern for registrants. This involves making better use of our data and being able to interrogate them in more useful ways, for example to see whether certain groups are more likely to have problems in certain areas and then to work out how we and/or other organisations can better support them to prevent problems arising.

We will provide this information to the profession to inform decision-making in respect of practice, CPD and behaviour. We are currently considering how best and how often to communicate this information for example: quarterly/annual bulletins (with all information appropriately anonymised and confidentiality respected).

¹³ <http://standards.gdc-uk.org/>

General Medical Council - The General Medical Council (GMC) publishes an annual State of medical education and practice in the UK, in which it analyses the nature of complaints it receives about medical professionals. This includes analysis of the sources of complaints, as well as which doctors are most likely to be complained about.

The GMC shares this data with its partners across the healthcare sector to inform their work.

We propose, from 2018 onwards, to publish an annual 'state of the nation' report on dentistry, similar to that produced by the GMC. The aim of the report would be to set out, in a clear and ordered format, a summary and analysis of the data that the GDC holds on the dental sector, exposing the available data and covering matters including: workforce; a summary of complaints and related trends; updates and analysis of activity within professional and system regulation; developments in dental services and service delivery, contextualised by an analysis of wider developments in healthcare regulation; and changes to NHS arrangements (e.g. contracts).

ACTION: GDC to develop, as part of its engagement strategy, an annual 'state of the nation' report on dentistry.

Working with partners to embed standards

Improving how we work with partners is a common thread running through everything we propose to do. As set out in the introduction to this document we intend to continue, in conjunction with those partners, to increase our intelligence picture, for example on standards that cause difficulty for registrants. We also intend to explore ways in which our partners can support us in maintaining the standards, by reminding registrants and other practice staff of the standards when inspecting them (e.g. display of clear price lists, registration numbers and opportunities for patient feedback).

One example of working with our partners to embed standards is in the difficult area of complaints handling. The GDC standards require all practices to have a complaints procedure, the NHS contract also requires this, as do multiple providers and some payment schemes. However, having a requirement in place is not necessarily enough to ensure a positive experience when making or handling a complaint. We have therefore contributed to the development of training on good customer service (including complaints handling) which is being offered by a major indemnity provider in partnership with NHS England. The training is open to non-members, is free and is open to all members of the dental team. This is a positive foundation on which we and a whole range of organisations could build, and we would welcome the development of initiatives from other providers in the sector.

There is a current trend for rapidly increasing representation of corporate bodies in dentistry. Data from 2014¹⁴ shows that in February of that year it was estimated that corporate groups operating three or more dental practices provided 22% of primary dental care (as measured by the number of practices and the number of dentists). This has nearly doubled from 12% in 2010. This provides opportunities to embed standards within practice, particularly in relation to harmonising performance management systems and appraisal linked to the Standards.

ACTION: GDC to work in partnership with relevant bodies to develop methods of linking the standards to performance management and appraisal.

We would welcome comments from registrants, employers and other interested stakeholders on how this could work in practice.

Supporting students

By engaging with and supporting students before they become registrants we can help ensure that they are well-equipped to understand and apply the standards expected of them as professionals. As with other upstream developments, the use of data and intelligence – from the GDC and others – is fundamental to identifying problems and developing solutions to address these at an early stage.

In line with our aim of engaging more effectively with registrants throughout their careers, we have developed a three-year student and new registrant engagement strategy, which will commence in 2017.

In developing our student and new registrant engagement strategy we undertook extensive external research, seeking feedback from students, registrants, other regulators and key stakeholders including education and training providers.

It aims to:

- contribute to harm reduction and improve safety by supporting students to develop their understanding of their responsibilities as a professional;
- improve student understanding of the role of the GDC, which will contribute to improving the GDC's relationship with registrants; and
- achieve engagement from students and new registrants in the GDC's policy development and operational improvement work.

The GDC's current role in education

The GDC's role in education and training is one of its four statutory functions. The Dentists Act 1984 requires the Council to 'promote high standards of education at all its stages' and sets out a range of obligations and powers to enable the GDC to pursue this aim, including the power to quality assure undergraduate education programmes for both dentists and dental care professionals (DCPs) and specialty training for dentists – a power not replicated for other post-graduate education or qualifications.

The Council's role in relation to education and training was last reviewed in 2008, so it is now time to look once again at this. The 2008 Strategic Review of Education produced a set of recommendations and objectives which set the focus of the GDC's work in this area, following which considerable work was undertaken to achieve these objectives, resulting in:

- the development of learning outcomes which put patient protection and patient expectations, including current and future oral health need at its centre, and the publication of these learning outcomes in the document *Preparing for Practice*:¹⁵
- clarifying the level of pre-registration training;
- shared learning outcomes across registrant groups;
- the involvement of lay people in the quality assurance process, including chairing inspection panels;
- an increased focus on the 'softer' skills required for dental care - professionalism, communication, team working, and management and leadership.

Further objectives were developed, following the Strategic Review, to enable the GDC to introduce a modern, transparent quality assurance process. Two notable developments were:

- *Standards for Education*¹⁶, which set out the requirements that all programmes leading to registrable qualifications must meet in terms of patient protection, quality evaluation, student assessment and equality and diversity; and
- *Standards for Specialty Education*¹⁷ which set out the requirements we are using to support the current revision of specialty curricula and training.

¹⁵ <https://beta.gdc-uk.org/professionals/education>

¹⁶ [https://gdcuk.sharepoint.com/sites/public/WebsiteFiles/Standards%20for%20Education%20\(v2%20revised%202015\).pdf#search=standards%20for%20education](https://gdcuk.sharepoint.com/sites/public/WebsiteFiles/Standards%20for%20Education%20(v2%20revised%202015).pdf#search=standards%20for%20education)

¹⁷ <https://gdcuk.sharepoint.com/sites/public/WebsiteFiles/Standards%20for%20Specialty%20Education.pdf#search=standards%20for%20education>

Developing our education strategy

Since 2008, both the education landscape and the practice of dentistry have developed considerably. The *Standards for Education* and the learning outcomes, contained in the document *Preparing for Practice*, were last revised in 2015 and will be reviewed regularly to ensure they remain fit for purpose and current. We also need to ensure that our quality assurance processes work on a continuous improvement cycle and learn from good practice, so that we operate our education function in the most effective and efficient way. This will enable us to continue to fulfil our statutory responsibilities and to support the present and future needs of patients, students and new registrants.

As set out above, and in line with our ambition to engage more proactively with registrants throughout their careers, we have developed a student and new registrant engagement strategy, with a range of aims including: promoting professionalism, encouraging understanding of and insight into the *Standards for the Dental Team*, and encouraging learning and continuous improvement initiatives.

Alongside this we need to examine the other aspects of what we currently do, and make sure they are suited to the changing landscape within dental education and practice. *Preparing for Practice*¹⁸ sets out the learning outcomes that must be achieved to successfully complete an education and training programme and be eligible to register with the GDC. Education providers are responsible for ensuring that their programmes and curricula meet the required outcomes for the award of the relevant qualification.

We need to ensure that these learning outcomes remain current and that they encourage innovation and development. However, this must be balanced against the impact on education providers of frequent changes to the requirements.

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

Our work on transition to independent practice in 2013 did not identify any specific or significant fitness to practise issues for new dentist registrants during the first years of registration. As we improve the quality of the information available to us and develop greater strengths in data analysis, we will look again at risks across different groups of registrants.

While we do not have specific powers of approval over Foundation or Core education and training for dentists, we have a duty to protect the public and consider that there is value in supporting these activities and the quality of education and training being provided. Through the monitoring and review of transition to independent practice, and ongoing engagement with relevant bodies, we will know more about potential gaps (as well as areas of good practice) which we can help to feed back to training providers.

¹⁸ <https://beta.gdc-uk.org/professionals/education/outcomes>

Developing quality assurance of education providers

The GDC currently inspects education programmes leading to registration as a dentist or DCP on a regular five to six year cycle with re-inspections required for some programmes where multiple or serious issues are identified. We monitor activity between inspections via an annual monitoring process.

Working with our stakeholders, we are developing a process for quality assuring specialty training. Implementation of this process will begin in 2017.

With a clear framework in place we are now well placed to develop systems that will enable us to apply our regulatory powers in a manner proportionate to the risk of a programme. In 2017 we will undertake a review of the quality assurance methods we utilise and the frequency of their use. This will assist us in determining the activity to be undertaken from the academic year 2018-9. The aim of this review will be to enable us to identify risk areas and target our quality assurance activity accordingly. This will include consideration of the balance of inspections and paper based activities, including monitoring, as well as the use of data from other internal and external sources.

Other healthcare regulators are keen to move the same way and we are working together to think about how this might be taken forward.

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

Supporting professionals from overseas

New registrants who have undertaken their training outside the UK may face specific challenges in their transition to working here. These may include understanding the workings of the NHS and contracts, adapting to different patient expectations or different ways of working within a dental team. We are considering the role we should play in assisting these registrants in overcoming such challenges and helping to ensure that avoidable problems for patients or registrants do not arise.

General Medical Council – Welcome to UK Practice (WTUKP)

The GMC runs half-day WTUKP workshops to help new doctors and doctors new to the UK to understand the ethical issues which will affect them and their patients in everyday practice.

Sessions include the role of the GMC, working through scenarios based on real-life practice situations and learning from the experience of senior doctors through 'Things I wish I'd known'.

99% of delegates say they would change their practice as a result of the course.

Source: GMC website, November 2016.

We therefore propose to develop materials, aimed at registrants from outside the UK, to ease the transition into practising in the UK.

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

Continuing Professional Development

Development and learning for professionals does not stop on qualification or registration. It should be, as referred to earlier, embedded throughout a professional's career, focused on providing high quality patient care and maintaining professional standards.

The GDC, in common with most other professional regulators, sets out requirements for CPD that are a condition of registration.

Research was commissioned by the GDC in 2011¹⁹ to enable a better understanding of the evidence on the impact of CPD in dentistry. The research took the form of a literature review, and looked at a range of studies on the impact of CPD.

One of the conclusions was that there was very little evidence to suggest that current models of CPD have an impact on the quality of care delivered, performance or competence. A further conclusion, however, was that the public expects professionals to keep their knowledge and skills up to date by carrying out CPD activities. We therefore need to close the gap between those two conclusions, and ensure that CPD meaningfully contributes to patient care, patient protection and professional development.

¹⁹ The Impact of Continuing Professional Development in Dentistry: A Literature Review (2011)

The current model

Currently, all registrants must complete a specified number of hours of CPD in order to maintain their registration with the GDC. The requirements are set out in secondary legislation²⁰ dating from 2008. The current requirements for dentists are that they must complete 250 hours of CPD within a five year cycle. Of those 250 hours, 75 hours must be verifiable. DCPs must complete 150 hours over five years, of which 50 must be verifiable.

The GDC currently strongly recommends that three topics which are important for patient safety are covered as part of the verifiable CPD requirement, for a varying number of hours: medical emergencies; disinfection and decontamination; and radiography and radiation protection.²¹ We also recommend that registrants undertake CPD on legal and ethical issues, complaints handling, early detection of oral cancer and safeguarding for children, young people and vulnerable adults.

Enhanced CPD

The enhanced CPD (ECPD) model, the pilot phase of which has recently concluded, makes some valuable changes to the existing model. One of the key aims is to encourage professionals to take a cyclical approach to their CPD, involving planning, undertaking and reflection, using a personal development plan (PDP). The five year cycle will remain the same. The key changes are:

- the emphasis on reflective practice, and the use of the PDP to identify learning needs and direct learning;
- removal of non-verifiable CPD;
- the reduction in the number of hours of CPD – 100 hours for dentists, 75 hours for most DCP groups, 50 hours for dental nurses and technicians;
- inclusion of provisions requiring CPD to be more evenly spread throughout the cycle.

Encouraging professional ownership

While the 2011 research concluded that there are limited links between the current model of CPD and improved outcomes for patients, there was evidence that not all CPD is equal in terms of quality or impact. The research highlighted the benefits of planning, self-directed learning and reflective practice, and we have sought to introduce these elements into ECPD via the personal development plan.

20 <http://www.legislation.gov.uk/uksi/2008/1822/contents/made>; <http://www.legislation.gov.uk/uksi/2008/1823/contents/made>

21 The third strongly recommended topic for dental technicians is dental materials.

There are also some less tangible benefits from CPD, including the opportunity for networking and contact with peers, which might be particularly valuable for those practitioners working alone or in other circumstances which mean they have limited interaction with other professionals. There is also, of course, the impact on public confidence in dental services, given the public expectation that professionals will undertake CPD activities to maintain their skills and knowledge and keep up to date with developments in their field.

If we accept the proposition that the reasons for requiring professionals to undertake CPD are broader than public perception and the opportunity for networking, we need to explore ways of increasing the emphasis on quality and outcomes from it than simply on the number of hours undertaken.

Each individual will take a different approach to their CPD, and indeed many professionals will already include significant elements of planning and reflective practice in their development. However, as with any such system, the range of approaches means that for some there are limited links to development needs. While ECPD, through the introduction of the personal development plan, goes some way towards addressing this, we need to consider whether this goes far enough.

A Personal Development Plan

- **is a tailored plan designed by each registrant that sets out their aims and objectives for professional development and learning over their CPD cycle;**
- **it should include: the CPD activities they plan to undertake during their CPD cycle, the high level learning outcomes that the CPD activities will aim to meet; and the timeframe for completing the CPD;**
- **it encompasses an element of reflection on activities once completed, including how the learning will be implemented into future practice; and**
- **is fluid and active – it can be adapted throughout the cycle if development needs change.**

Our implementation of ECPD, which, following feedback from the pilot scheme, will not take place before January 2018, represents a significant first step in promoting ownership of CPD by professionals. Based on that feedback we now propose to explore how we can further empower registrants by increasing the value to them and to patients of CPD.

We therefore want to explore with professionals how we can go further in making CPD the responsibility of the profession, with the role of the GDC being a supportive one, providing data, intelligence and information to assist professionals in determining their development needs. For example, we might aim for greater agility in recommending topics, basing them on evidence such as our fitness to practise data, enabling professionals to tailor them to their practice.

We also want to explore ways of promoting professional bodies to drive innovations in CPD planning, activity and monitoring. In this way, the GDC would share the responsibility of professional development by providing space for others (such as local professional networks and associations) to build supportive assurance mechanisms around the core scheme. This would require the GDC to place less emphasis on detailed checking and more on building partnerships and setting frameworks. The Engineering Council provides an interesting example, where it licences professional engineering institutions to establish and implement appropriate policies and practices for CPD.

What we aim to do by opening the discussion on this topic is to explore the acceptable limits of that responsibility in the short, medium and long term.

ACTION: GDC to develop a model which encourages and enable professionals and professional bodies to take ownership of CPD planning, development and innovation.

We would welcome feedback on the benefits, risks and limitations of moving towards a model of CPD with an emphasis on increased professional ownership.

A quality based approach

Some regulators, including the GMC have moved away from CPD schemes based on the number of hours, and towards more qualitative, reflective models, with the onus on the professional to identify their own development needs and undertake the appropriate CPD to address them. However, this process requires a robust system of appraisal and clinical governance and is overseen by 'responsible officers' with statutory responsibilities.

The GMC approach – revalidation

- The process by which all licensed doctors must demonstrate every five years that they are up to date and fit to practise.
- The GMC's 'good medical practice' framework sets out four main domains: knowledge, skills and performance, safety and quality, communication partnership and teamwork, and maintaining trust.
- Doctors use the framework as a basis for the revalidation process to demonstrate that they are fit to practise.
- Revalidation is driven through the appraisal process, in which doctors discuss their practice and performance with their appraiser, and reflect on the supporting information they have gathered to demonstrate their fitness to practise. They also identify areas of practice in which improvements and further development are required.
- Supporting information includes: CPD, quality improvement activities, significant events, feedback from colleagues and patients, review of complaints and compliments.
- There are no quantitative requirements for CPD: the doctor is required to identify the CPD required to improve their practice and undertake it.

As is clear from the GMC example above, the regulatory landscape in medicine is quite different to that in dentistry, and the challenges of introducing a less prescriptive and more professional led model would therefore also be different. However, there is merit in considering options for giving ownership of CPD to professionals, and fully exploring the advantages and disadvantages for all parties in a model based on individual learning needs, quality of CPD and outcomes from it.

The Health and Care Professions Council (HCPC) presents an interesting comparison with potential schemes for the GDC as it regulates 16 professions and recognises that a flexible approach to CPD is crucial to maintaining proportionality across professions. The scheme recognises a multitude of CPD activity types, and requires that their registrants demonstrate a mixture of activities relevant to their practice.²² They do not set a minimum requirement for CPD, but place the onus on the professional to demonstrate professional judgement surrounding their activity planning. The scheme emphasises continuous development and recommends that activity takes place at least every two months, with gaps of more than three months requiring explanation.

Outside healthcare, the Solicitor's Regulation Authority has recently shifted its requirements from quantitative (mandatory CPD hours) to a qualitative, reflective approach, branded 'continuing competence'.²³ The SRA has developed a competence statement which sets out the competences that are required by solicitors to maintain their registration. It is expected that solicitors structure their own professional development by reflecting on their practice and addressing development needs to meet these competences.

²² HCPC- 'Standards for CPD' - <http://www.hpc-uk.org/registrants/cpd/standards/>
²³ SRA- 'Continuing competence' - <https://www.sra.org.uk/solicitors/cpd-accreditation.page>

The role of the regulator

While determining their own development needs is a matter for individual professionals, in conjunction with their employers, the role of the regulator is to ensure that the CPD scheme is appropriate and in line with our overall objectives, most importantly patient protection. In a model owned by the profession, the GDC's role, in addition to setting out the framework within which professionals should undertake and record their CPD, would be threefold:

- providing information and intelligence to inform professionals' CPD decisions;
- where the intelligence suggests themes or issues that need to be addressed, making recommendations for topics to be covered by CPD;
- developing and overseeing a profession-led assurance model.

As with all activity to prevent harm, using information and intelligence effectively to determine the areas of focus is important for patients, the profession and the GDC. It enables professionals to gain insight into potential risk areas, and to take action to mitigate them.

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.

We would welcome feedback on the principles and practicalities of developing a quality-based model of CPD and on the utility of quantitative requirements (e.g. hours).

Learning methods

There are other potential drivers for informing CPD activity, including its link to the potential increase in a professional's scope of practice. Additionally, we could look to key expert bodies (e.g. Health Education England, NHS Education for Scotland, the Royal College of Surgeons, the Northern Ireland Medical and Dental training Agency, the Faculty of General Dental Practice) to take further ownership of professional development, by identifying and recommending CPD topics based on dental sector or broader public health sector concerns. In doing this we can learn from some of the innovation already underway, for example as part of the Translation Research in a Dental Setting²⁴ (TRiADS) collaboration programme in Scotland, which seeks to support the translation of knowledge into practice and aims to develop and evaluate the implementation of strategies to improve the knowledge-to-practice gap in primary care dentistry in Scotland.

Quality of outcomes is linked to the quality and means of delivery of the CPD itself. As noted above, the 2011 research highlighted the benefits of planning, self-directed learning and reflective practice as well as the fact that better outcomes resulted from certain types of CPD activity, namely sustained, repeated or longer-term activities. There is also anecdotal evidence to suggest that CPD which involves interaction with professional colleagues has significant benefits when compared with other non-interactive activities, e.g. reading, or online CPD. While there is room for a mix of CPD activity, we all need to consider how to ensure that the benefits of interactive CPD are recognised and realised. Activities such as coaching and mentoring, where individuals are supported by other members of the dental profession, also have an important role to play here, and are valuable ways of enhancing the skills and approach of all involved.

Other health regulators have already begun to develop their CPD schemes to promote interactive, quality driven activity for their registrants. The General Optical Council model recognises the importance of 'interactive' points in their Continuing Education and Training scheme (CET). Within the three year cycle, they prescribe that at least half of the registrants' points must be acquired through interactive types of learning, which involves physical attendance at activities such as lectures, workshops or peer review events, or interactive distance learning. There is an additional requirement for some registrant groups to participate in formal, case based discussion groups.

ACTION: GDC to incorporate an emphasis on interactive CPD into the developing model, and explore the risks and benefits of this.

²⁴ <http://www.triads.org.uk/>

Peer review, support and assurance

Alongside emphasising the importance of interactive CPD, we would also be keen to see collaboration between registrants via peer review processes. The GOC specifically recognise 'peer review events', which it allows registrants to set up through their online CET system, and where points can be directly recorded. CET providers can also arrange these for registrants.²⁵ The intention of these events is to prevent registrants from becoming isolated and encourage sharing of experiences and expertise. Within the GDC context, peer review activities would need to be flexible to suit the mix of registrants and their practice settings.

We need to consider how to assure the quality of CPD. Some of the responsibility and ownership of this could, however, rest with the profession, in the form of peer review/support networks, with an emphasis on professionals supporting each other through, for example, local professional networks. The GDC is at the early stages of considering whether this might work within dentistry, given the disparate and complex nature of business models and range of registered professions. It is worth considering how CPD policy and guidance could be used to positively incentivise the CPD provider to embed quality assurance measures in their courses. One option could be to link CPD activity with the gaining of additional skills for DCPs within their scope of practice. We are exploring ways in which CPD courses could be accredited in order to improve quality, without increasing costs for registrants, and how we could support this with guidance.

ACTION: GDC to incorporate a significant peer review element into the developing model, and explore the risks and benefits of this.

We would welcome input on the development of peer review frameworks, particularly in relation to the benefits, risks and limitations.

²⁵ GOC model - 'CET guide' <https://www.optical.org/en/Education/CET/index.cfm>

2. First tier complaints resolution

Even with an increased focus on prevention through upstream activity, it is inevitable that sometimes things will go wrong, and a patient will wish to make a complaint. In recent years, societal influences, coupled with changes to healthcare funding models, have led to changes in the relationship between dental professionals and patients and an increase in the number of people raising concerns with professional regulators²⁶. The fact that most patients now pay for, or make a financial contribution towards, their treatment means that the patient-professional relationship is arguably more complex than in some other areas of healthcare: it comes with a ‘consumer’ dimension, which has an impact on patient expectations. This means that dental professionals need to be equipped to manage those expectations, and to deal with patients appropriately and sensitively when they are not met.

The Professional Standards Authority has set out the principles of good regulation and what this means in practice in its publication *Right Touch Regulation*.²⁷ A key element of this is seeking solutions as close as possible to the problem for the benefit of both the patient and the professional. In the case of dentistry, this usually means within the practice or other care setting.

We know that complaints can be difficult to manage, but it is important that everyone involved in patient care understands the importance and the principles of good complaints handling.

We also know that most complaints received by dental professionals are resolved quickly and effectively,²⁸ but good practice is not as widespread as it needs to be to enable the system of regulation to work well for everyone. The GDC receives a large number of complaints that do not raise issues that can or should be resolved through a fitness to practise investigation. While the GDC does not and should not investigate these matters, they do need to be addressed, and the best place for this to happen is very often in the practice or care setting. We want to work with the profession to ensure that resolution is sought and found in the most appropriate place. This involves ensuring patients know how, and feel confident, to raise their concerns by the most appropriate route. It also means working to maintain high standards in complaint handling across the profession.

In order to inform this work we are gathering and analysing the available intelligence – both our own and our partners’ - on complaint handling. Our initial findings indicate that most dental practices have complaints handling procedures, and are following them. For example, as part of a CQC inspection in England, a practice’s complaints handling procedure will be checked. As shown in figure 4, CQC 2015/16 inspections data²⁹ show that 90% of inspections have the outcome ‘no action required’, meaning that they were not found to be in breach of any of the CQC’s regulations.

26 In response to a considerable increase in the number of fitness complaints and enquiries, the GMC commissioned a piece of research to better understand the reasons for this rise. The resulting report, published in 2014, found that there are many possible explanations rather than one definitive answer, with explanations including a changing doctor-patient relationship; more empowered patients; increased use of the internet and social media; and increased awareness of how to complain if patients are unhappy with their treatment. The full report is available at http://www.gmc-uk.org/static/documents/content/Archer_et_al_FTP_Final_Report_30_01_2014.pdf

27 <http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf?sfvrsn=12>

28 Based on CQC inspection data and reports which suggest that the majority of practices have, and follow, a complaints handling procedure; and NHS Digital data on the numbers of written complaints received by dental practices in England and Wales.

29 The state of health care and adult social care in England, 2015/16. Care Quality Commission, available http://www.cqc.org.uk/sites/default/files/20161019_stateofcare1516_web.pdf

Figure 4: Graph showing outcomes of 2015-16 CQC inspections into dental care, as at June 2016

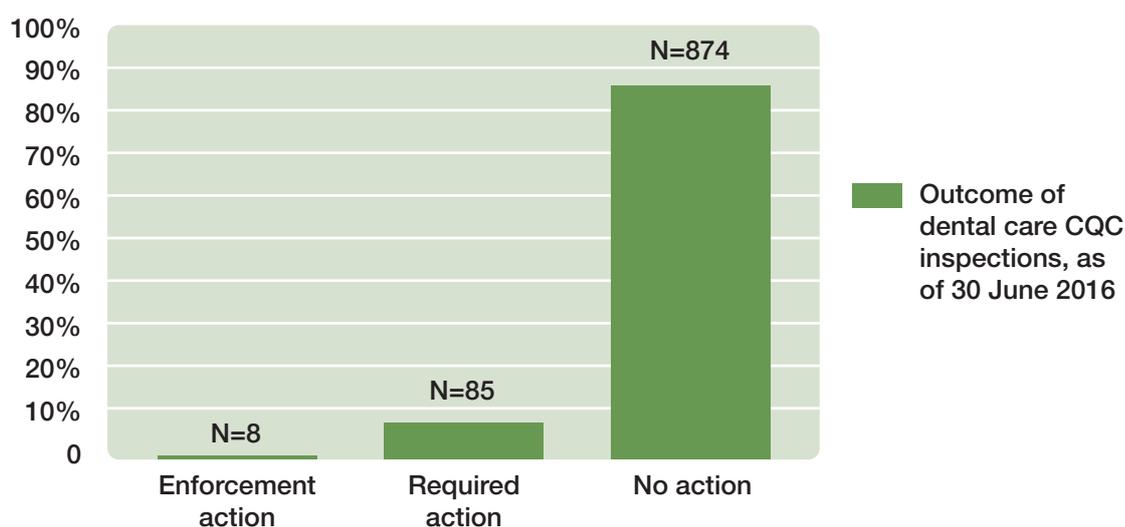


Figure 5 below shows that of the 93 practices where one or more regulation was breached, only seven locations breached Regulation 16 *receiving and acting on complaints*.

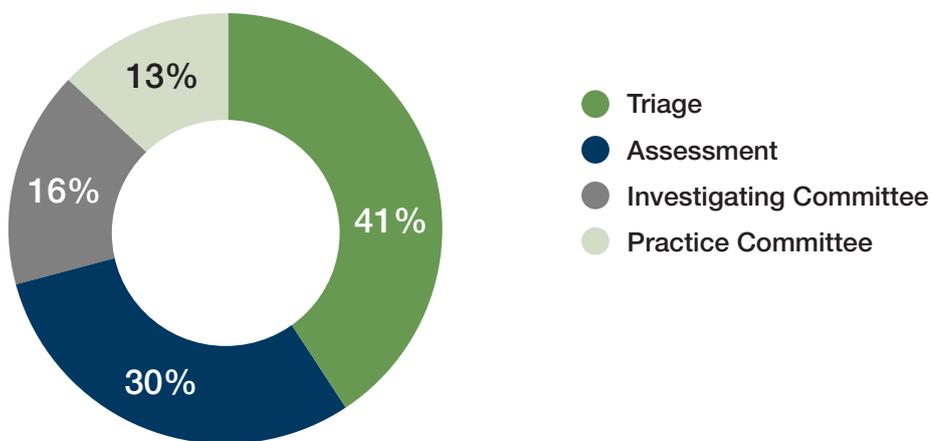
Figure 5: Number of CQC inspected locations where regulatory breaches occurred, 2015-16

Regulation Number	Regulation Name	Total number of locations where breached
Regulation 7	Requirements relating to registered managers	1
Regulation 9	Person-centred care	3
Regulation 10	Dignity and respect	2
Regulation 11	Need for consent	1
Regulation 12	Safe care and treatment	42
Regulation 13	Safeguarding service users from abuse and improper treatment	11
Regulation 15	Premises and equipment	6
Regulation 16	Receiving and acting on complaints	7
Regulation 17	Good governance	76
Regulation 18	Staffing	21
Regulation 19	Fit and proper persons employed	30

Data from the Dental Complaints Service ('DCS' - a service to facilitate the resolution of complaints about privately funded dental care) suggests that a significant proportion of complaints can be resolved satisfactorily when directed to the practice. When the DCS receives a complaint about private treatment, it is made clear to the patient that the DCS will not assist until the registrant has been provided with an opportunity to respond to the complaint first. After three weeks, patients are contacted to see whether their complaint has been resolved. More than 85% of cases are resolved at this stage.

While there is evidence to show that almost all practices have complaints handling procedures in place, and in many cases these are effective in resolving complaints, the GDC still receives many complaints that could have generated better outcomes for both the patient and the professional had they been handled more effectively in the practice. As shown in figure 6, 71% of cases received by the GDC in 2015 were closed at either the triage or assessment stage, meaning that the issue as identified by the complainant did not amount to an allegation of impaired fitness to practise.

Figure 6: Chart showing the stage at which GDC fitness to practise cases were closed, 2015



The fact that the GDC continues to receive a significant number of complaints which do not raise an allegation of impaired fitness to practise shows that there is still more that can be done to strengthen first tier resolution. The GDC wants to work with the profession and our partners to build on the good practice that already exists to maximise the potential of local resolution.

Working together to support good complaint handling

There are several ways in which the GDC, the profession and our partners can support early and positive complaint resolution, resulting in better outcomes for patients and professionals. Some of them are captured in our proposals for upstream engagement and activity, including the embedding of good practice in pre-registration training, and encouragement of CPD on relevant topics. Management of feedback and complaints is one of the aspects of the *Standards for the Dental Team* on which we will gather data and intelligence and use it to inform the profession and our own upstream activity. Just as we encourage professionals to develop and maintain their expertise in their clinical practice, so would we encourage development of 'softer skills' and business management skills where appropriate.

We have identified some specific ways in which the current upstream activity in relation to complaints handling could be increased and improved, including provision of tailored material upon registration. The 'welcome pack' provided to dental professionals upon registration has been identified as an opportunity to provide context to the standards and supporting guidance documents in general, which could include information on the principles of effective complaints handling.

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.

In addition to this upstream activity there are other ways in which the GDC and the profession can jointly seek to both prevent complaints, and ensure that when they arise, they are swiftly, sensitively and thoroughly dealt with. We are currently working on a profession-wide complaints handling initiative to share good practice and bring about improvements. A working group drawn from a range of organisations across the profession is considering:

- examples of current good practice;
- barriers to effective complaints resolution in practice and how they can be overcome;
- what we can all do to encourage patients to use local resolution when appropriate; and
- how to embed a culture in which complaints provide learning for service improvement.

ACTION: GDC to continue to develop a profession-wide complaints handling initiative to strengthen first-tier complaint resolution.

Encouraging early resolution

As noted above, one of the challenges in resolving complaints in the practice is influencing patient behaviour, encouraging them to seek resolution of problems at an early stage with the professional from whom they have received care. Patients therefore need to feel able to approach the practice or treatment provider with feedback. Our preliminary analysis of the available data and information,³⁰ summarised in the box below, on the willingness of patients to complain to care provider indicates that many are, but that there is clearly more to do. Whilst remaining sensitive to the concerns of patients who may not initially feel comfortable complaining to the practice, we believe that with the right assurances from effective complaints procedures, information on what to expect, and approachable and welcoming cultures in practices, patients can be encouraged to resolve less serious complaints locally.

Patient willingness to use in-house complaints procedures

Patients in general practice can be unwilling to complain directly to the practice and especially to the staff involved

Patients Association Report, 2015

40% of dental patients who had complained or considered complaining about a dental professional would complain to the practice

GDC survey of patients and public, 2016

Some patients will look to resolve issues locally while others are concerned about being 'struck off' surgery lists

GDC patient stakeholder event, 2016

A significant part of this is ensuring that the information available to the public about raising concerns is clear and accessible, including information provided by our partners. In Scotland, for example, we have worked closely with the Patient Advice and Support Service and the NHS Patient Complaints Association to deliver training to their advisors. Later in this document we will set out our proposed actions for reviewing our own public information to signpost patients and the public when raising a complaint. This includes initiatives that are already underway, such as changes to the GDC's website (see section 4 for more on this) and the information provided by the GDC's customer services advisors to those enquiring about how to make a complaint. It is also likely to include developing a better understanding of the barriers to taking a complaint to the practice, and using this evidence to develop an interactive platform on the website to signpost patients to the most appropriate place.

³⁰ Unpublished report from the Patients Association on improving complaints handling in primary care suggests that patients (General Practice) can be unwilling to complain directly to the practice where they received their care, especially directly to those staff who have provided their treatment. The GDC patient and public survey 2016, available at <https://beta.gdc-uk.org/about/what-we-do/research>, shows that 40% of those who had complained or considered complaining about a dental professional had done so (or considered doing so) to the practice where the treatment was carried out. Qualitative information (unpublished) from the GDC's corporate strategy event showed that whilst some patients will look to resolve issues locally in the practice they attend, there can be concerns about consequences for complaining – such as the impact on their treatment and being 'struck off' the surgery list.

The Regulation of Dental Services Programme Board (NHS England, the NHS Business Services Authority, the Department of Health, the CQC, the GDC and Healthwatch England) have published a statement on dental complaints to ensure there is a shared understanding of the correct route for complaints among providers.

The statement was produced in recognition of the fact that:

- the dental complaints system is complex and confusing for patients, providers and regulators – especially given the mixed public/private provision of dental services;
- overlaps between organisations bring a lack of clarity, with multiple organisations potentially responsible for different aspects of the same complaint;
- there is a lack of consistency: different organisations are subject to different timeframes for dealing with complaints, and cover different nations of the UK; and
- patients who initially approach the ‘wrong’ body may then be lost to the system completely.

The primary audience for the statement is providers, who will be able to check that their patient-facing materials and processes are compatible with it. The national bodies that are signed up to the statement will also use it as a basis for their communication with patients.

<http://www.cqc.org.uk/content/regulation-dental-services-programme-board-rdspb>

It is also vital that the information available to patients in the care setting, clearly sets out what they can expect from the process and what their options are so that patients feel informed and reassured in taking their complaint to the practice.

This links closely to the initiatives we are exploring with our partners on how complaints can be handled by the most appropriate body. More detail on this is contained in section 4 of this document.

Any work carried out in this area must ensure that patients have their complaints and concerns listened to, acted upon and responded to by the organisation that can provide the most appropriate path to resolution. In cases where the GDC is not best placed to resolve the complaint, the benefits of local resolution must be clearly communicated, so that the patient feels confident that their voice will be heard.

Supporting and encouraging good complaints handling

While complaints handling is included in the *Standards for the Dental Team* the GDC clearly cannot ensure that good practice is followed in every case. Responsibility for quality management and improvement must rest with professionals, with appropriate support from the GDC, system regulators, professional bodies and indemnity providers. This includes encouraging learning from complaints and feedback and using it to improve services and prevent future complaints.

Training on customer service and effective complaint resolution is an important part of ongoing development for dental professionals, and should be incorporated into pre-registration training and CPD. Help and support in handling and responding to complaints is also widely available from organisations such as indemnity providers and professional associations. However, not all dental professionals are seeking help and advice when needed, refreshing their customer service skills, or using the feedback from complaints to improve services in the practice.

CQC inspection reporting helps to shed light on common characteristics of both good and poor complaints handling procedures, as demonstrated in the following tables:

Common characteristics of poor complaints handling

A review of a number of CQC reports which found poor performance in complaints handling highlighted the following issues:

- patients not being made aware of the complaints process;
- policy does not include who to contact or timescale for a response;
- complaints not adequately logged;
- action taken in response to complaints not recorded;
- no systems in place to respond to verbal comments or complaints
- staff not recognising concerns as complaints;
- staff not having adequate training to deal with complaints;
- opportunities to learn from complaints and improve quality of service not taken; and
- no way to assess the quality of service through anonymous feedback, questionnaires, comments box or website.

Notable practice in complaints handling

A CQC inspection report published in July 2016 identified ‘notable practice’ with regards to handling complaints and using feedback to improve services.

As a direct result of complaints received from patients, the practice manager introduced customer service training for reception staff. The practice manager followed this up by asking staff to complete a quiz about customer service, which included such things as the importance of making eye contact with patients. The practice also introduced training for all other staff.

To address concerns or complaints about waiting times, as it had received complaints of this nature, the practice also provided a leaflet for patients to explain why the dentists may be running late. Any complaints were comprehensively discussed in staff meetings and the practice manager ensured that staff had learned from previous complaints. The whole process was well-documented and detailed.

This is notable practice because of the commitment to learn from complaints.

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.

Encourage patient feedback in the practice

One of the key themes in all our proposals is better use of data, information and intelligence to inform not only our activity but that of our partners and the profession. Patient feedback is a very valuable form of intelligence, particularly when seeking to improve and develop services, determine CPD requirements or reflect on the effectiveness of CPD. We would encourage professionals, as part of a joint effort to improve outcomes for patients, to actively seek feedback from patients and use it to improve performance and identify where changes within the service are required. Acting on feedback reassures patients that they are being listened to and can prevent future complaints.

Encouraging and using patient feedback to improve services is likely to be practice led – with practice management and administration taking a lead role. As such, this is something that will be considered as we revise our guidance for employers (for more on this see section 3.)

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.

Expanding access to independent complaint resolution

There are clear benefits for patients and professionals in a system which enables early, quick and low-cost resolution of complaints and disputes. This is particularly true in an environment where patient expectations are increasing, and professionals find themselves navigating unfamiliar territory when faced with complaints, sometimes feeling unable to seek the support of their colleagues or peers.

As highlighted by the statistics, a large proportion of the matters referred to the GDC do not raise a question over a professional's fitness to practise and are often complaints that could or should be resolved between the patient and the practice. There are, however, sometimes barriers to patients in seeking such resolution, including reluctance to complain direct to the practice, or a lack of understanding about how a complaints procedure works.

It is important that patients for whom such barriers exist are not prevented from seeking resolution and that measures are in place to enable them to do so. The GDC therefore believes that mechanisms to facilitate local resolution through liaison and mediation are necessary and valuable in ensuring positive outcomes for patients and professionals, and reducing the regulatory burden.

Facilitated resolution: the current position

The process for making a complaint about dental treatment across the UK varies according to whether the treatment in question was delivered privately or under the NHS, although this may not always be clear to patients. In the case of NHS-funded treatment there is a statutory complaints scheme, which sets out the requirements on complaints handling for providers, including dental professionals, and the NHS.

Until 2006, no mechanism for resolving complaints about privately funded dentistry existed, prompting the GDC to establish the Dental Complaints Service (DCS). In its first ten years of operation, the DCS has become a well-respected and cost-effective resolution service, highly rated by the patients and professionals who use it.

The DCS model is simple. It:

- provides an **advocacy** service for patients, helping them understand the complaints process and set out their complaint clearly and constructively. In more than 85% of cases, this is the only intervention that is required to resolve the complaint;
- **facilitates** constructive discussions between the patient and the professional. Around 13% of complaints are resolved at this stage;
- provides non-adversarial **independent panels** to resolve the very small proportion of complaints that remain. The panels comprise volunteer clinicians and non-clinicians.

As well as the high satisfaction ratings from its users, the DCS delivers significant cost savings by dealing with many cases that might otherwise have come to the GDC. The average cost of a complaint managed through the DCS is approximately £210, compared to an average of £61,000³¹ for a full fitness to practise investigation and final hearing. Making more use of this form of resolution therefore makes sense from the point of view of benefits to patients, service to professionals and reducing cost.

We now intend to take forward work in four areas:

- Developing new ways of promoting the benefits of this form of resolution, in conjunction with dental professionals. In order to be most effective, patients and professionals need to understand the benefits of quick and early resolution, and how they can access it. It is important to distinguish between *promoting proportionate resolution* and ensuring that patients know how to access services to assist with this, and *encouraging* them to complain where it is not justified. Part of this might involve ensuring that the name and how we explain the role of any future service clearly reflect its function.
- Exploring with the profession and its representatives the benefits of integrating a mediation service into practice complaints handling processes so that it is clear to patients that there is an alternative route to try before raising a complaint with the GDC.
- Extending the availability of the advocacy element of the service – supporting patients in finding the right home for their complaint and helping them express it clearly and constructively – to patients of NHS-funded treatment. Currently more than 40% of callers to the DCS wish to complain about NHS funded treatment. While we have no current plans to extend the *facilitation or resolution* elements of the service to such patients, the costs of limited additional support in the first stage are likely to be marginal and the benefits potentially very significant.
- As set out in our corporate strategy *Patients, Professionals, Partners, Performance*, we will proceed with plans to extend coverage of the service to those with pre-payment plans for private dental care.

To support this work and other elements of our reform plans – for example, effective routing of fitness to practise cases – we will be reviewing the current operation of the DCS in 2017 with a view to informing the shape of any future service.

³¹ Average based on figures from 2015 for a case which progresses to a full hearing.

Who should run the DCS?

It is unusual for a regulator to pay for and run what is effectively an independent resolution service. Such services are often provided by the regulated sector itself, entirely separate from the regulator. The GDC established the DCS because it filled an important gap in service to both professionals and patients. While we will continue to ensure the service is provided, there is no overwhelming reason why it should not be delivered and funded by a third party. We will be exploring options with the profession and others.

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.

3. Working with partners

We committed in our corporate strategy to work better with our partners to improve the regulation of dentistry in the UK. We have touched elsewhere in this document on the fact that the GDC cannot bring about the change needed without the support of the profession and our partners. We have been working hard to improve this and have, in recent years, established closer working relationships with systems regulators and the NHS in the four nations, resulting in initiatives to ensure that we are using our regulatory powers effectively.

In England, a key aspect of this is our involvement with the Regulation of Dental Services Programme Board (RDSPB), led by the CQC. This forum has brought together the key players in dental regulation in England, with the aim of ensuring that issues and concerns are addressed proportionately and by the most appropriate body. The RDSPB is made up of the CQC, NHS England and the NHS Business Services Authority (NHSBSA). Other partners, include Health Education England, Healthwatch England and the local Healthwatch network. The primary aim of the RDSPB is to make dental regulation more coherent, streamlined and effective by addressing gaps and overlaps in the current system. The scope of the work is predominantly focused on primary care but also takes into consideration implications for secondary care as well as social care.

In Scotland, we are members of a working group which aims to promote a uniform approach to managing complaints and disciplinary procedures relating to the conduct and performance of dentists. Currently, the health boards in Scotland adopt different approaches which can be challenging for dental professionals. The group is chaired by the Chief Dental Officer and includes NHS Education for Scotland, the Medical and Dental Defence Union of Scotland, BDA and representatives from the NHS health boards.

RDSPB joint operational protocol

An important aspect of the work of the RDSPB has been the development of a joint operational protocol which the GDC, the CQC and NHS England, are currently piloting.

The protocol aims to:

- **clarify roles and responsibilities between the GDC, CQC and NHS England;**
- **establish a process for early conversations about which organisation should manage a particular issue; and**
- **promote a fairer and more proportionate system for registrants.**

This is designed to reduce overlap in regulatory processes where possible and to enable the organisations to share information more effectively.

However, there is more to do, and we need to develop our relationships with a whole range of organisations, including the systems regulators and the NHS in each of the four nations, professional associations, indemnity providers and employers, including, of course, corporate providers of dental services. These relationships are important for many reasons including, among others, to demonstrate commitment to maintaining high standards, information sharing and avoiding over-regulation.

Working in partnership with others, including the CQC and NHS England, we are already developing plans for an operational board for dental regulation. This will build on the work of the RDSPB, and will be responsible for developing and implementing mechanisms for:

- ensuring that the right issue is dealt with by the right organisation at the right time;
- making the best use of data and other information held by the partners to develop a shared view of sectoral risk to enable more effective use of resources; and
- supporting effective liaison between partners at local and regional levels.

We will continue to work with the Chief Dental Officers (CDOs), the NHS, the health Departments and the systems regulators in England, Wales, Scotland and Northern Ireland, to achieve the objective of a more proportionate system of dental regulation.

Leadership in the profession: setting the agenda on clinical governance

‘Clinical governance’ is a term used to describe systems designed to improve the quality and accountability of healthcare. This includes identifying and responding to poor practice, learning from incidents and taking steps to prevent recurrence. The effectiveness of clinical governance can have a significant impact on patient care. In regulatory terms, good systems of clinical governance should recognise and deal with risk early, before regulatory action is required.

For a range of reasons, clinical governance in dentistry has become somewhat eroded over time in comparison with other aspects of primary care. While guidance and support from the NHS, indemnity providers and professional bodies does exist, the responsibility for establishing the appropriate mechanisms at the local level often rests with the leadership of a practice, or indeed with individual practitioners. While the influence of the corporate sector is growing, most dentistry is still provided in single independent practices or small groups of independent practices, and while good clinical governance is a requirement of the NHS contract, it is not always easy to establish within this environment.

There are three major implications of this for the quality and effectiveness of regulation:

- The comparative absence of formal clinical governance structures means that there are more limited opportunities for learning and improvement, making it harder to identify and manage concerns before they become public protection issues. This in turn impacts on the regulatory workload. In effect, dental professionals are subsidising, to a certain extent, weaknesses in clinical governance by paying for increased volumes of costly regulatory enforcement activity.
- If clinical governance is ineffective, local mechanisms for handling complaints may not be adequately supported or advertised to patients, meaning that complaints that could be resolved appropriately at the local level are more likely to be referred to the regulator. By way of illustration, in 2015 the GDC received 2786 complaints, of which 318 received a hearing at a practice committee.³² In medical regulation, however, which has a more developed system of clinical governance, the General Medical Council received 9418 complaints in the same year but progressed only 239 to a hearing.^{33,34}
- Leadership of the profession tends to be somewhat fragmented, not only across the various professional groupings that make up the dental team, but also within them. There is no unified Royal College of Dentistry, for example.

This in turn makes it harder, arguably, for the profession and those who design, arrange or commission dental services to take real ownership of public protection and quality improvement in the way that has been demonstrated in some other areas of healthcare. This is a challenge that the profession and those who commission services are likely to need to find ways to address if the regulatory system is to be truly capable of working in the best interests of both patients and professionals.

32 https://gdcuk.sharepoint.com/sites/public/WebsiteFiles/2016-06-09_10%20-%20Annual%20Report%20and%20Accounts%202015..pdf#search=annual%20reports%20and%20accounts

33 General Medical Council, Fitness to practise statistics 2015. http://www.gmc-uk.org/DC9491_07___Fitness_to_Practise_Annual_Statistics_Report_2015___Published_Version.pdf_68148873.pdf

34 The 2015 figures for both regulators are broadly consistent with those of recent years.

The essential components of clinical governance

- ▶ **Risk management:** identifying what can and does go wrong during care, learning lessons from any adverse events and taking action to prevent recurrence
- ▶ **Clinical audit:** measuring the quality of the care offered and using information to identify opportunities for improvement
- ▶ **Patient, carer and public involvement:** developing an understanding of the priorities and concerns of people who use dental services
- ▶ **Staff and staff management:** ensuring that highly skilled staff are working in efficient teams in a supportive environment
- ▶ **Education, training and CPD:** ensuring that staff involved in patient care have the knowledge and skills they need, and that they are given opportunities to keep their skills and knowledge up to date
- ▶ **Information management:** proper collection, management and use of information in the clinical setting
- ▶ **Clinical effectiveness:** basing patient care on good quality evidence from research

We recognise of course the concerns that many in the profession have about the way that dental services are paid for and commissioned and the perverse incentives that some are concerned are embedded in the current system. The dental contract is a key influencer of behaviour and we welcome and support the intent of reforms to focus more on prevention and quality.

Regardless of the infrastructure around dental provision, however, we see the potential for greater leadership by the profession and those who administer systems, including NHS commissioners and service designers/arrangers, in embedding clinical governance within dentistry and using it effectively to develop a culture of quality improvement and learning. In developing the approach to clinical governance, professionals and those involved in arranging or commissioning services might seek answers to questions like:

- To what extent are patients fully informed about the costs, benefits and risks of treatment options?
- What is the level of complaints across the whole dental system and how is that changing?
- How frequently do 'never events'³⁵ occur and what is being done to learn from them?
- How well is unnecessary pain being managed? How well is unnecessary anxiety being managed?
- Is the public becoming more or less likely to take up dental services? Why?

The answers to these and many similar questions ought to lead to the development of a suite of indicators of public protection. This would represent a significant step forward in the collective understanding of dentistry and provide a much stronger platform for answering questions like how much regulation is needed, and what sort of commissioning arrangements are likely to make the most effective contribution to public health. It is a challenge we set out for professionals, commissioners and employers.

³⁵ <https://www.england.nhs.uk/patientsafety/never-events/>

There are examples of innovation in clinical governance in dentistry, and we want to see how these can be developed further, under the leadership of the profession. Quality improvement is one of the work streams under the RDSPB, and is being led by the office of the Chief Dental Officer in England. This work seeks to utilise existing networks, including Local Dental Committees and Local Dental Networks to establish an open learning culture, with structured intra-professional peer support, with dental clinicians monitoring and regulating their own clinical performance.

Scotland: practitioners with problems

The practitioners with problems working group, led by the Chief Dental Officer in Scotland, has established a three-stage process for managing complaints and disciplinary procedures for dentists.

There is a strong emphasis on local management and resolution of issues via meetings and discussions, beginning informally (stage 1), and progressing to more formal meetings as necessary (stage 2). Should a concern not be raised at the first or second stage, the final stage sees the practitioner formally referred to the Reference Committee, which will decide whether the practitioner has failed to comply with their Terms of Service, and whether the matter should be referred to the Discipline Committee. Both the Reference Committee and the Discipline Committee can, where there has been a clear and serious departure from the Standards for the Dental Team, refer to the GDC as part of the outcome.

All three stages are underpinned with guidance for those involved on the triggers that should result in a referral to the GDC for an interim order.

NHS Improvement published National Safety Standards for Invasive Procedures (NatSSIPs) in 2015, which brought together national and local learning from the analysis of never events, serious incidents and near misses into a set of recommendations aimed at helping to provide safer care for patients undergoing invasive procedures.

Organisations are expected to develop their current processes for invasive procedures and ensure they are compliant with the NatSSIPs. An example of the profession taking the lead on clinical governance is the significant project, currently underway and led by the Faculty of General Dental Surgery at the Royal College of Surgeons, to develop Local Safety Standards for Invasive Procedures (LocSSIPs), which focus on the prevention of, and learning from, never events.

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’.

Support for employers

The structure of the dental sector is changing rapidly, particularly in relation to the volume of dental services that are provided through 'corporate' practices.

We know that the expansion of the corporate sector is a feature of the dental landscape that is controversial in some quarters. It is one, however, that is likely to be here to stay. Given the increasing sophistication and maturity of some of the businesses in this sector, we must ask ourselves what role the leadership of those organisations can play in securing high standards of dental care.

In many sectors, primary responsibility is placed on the businesses providing goods and services to ensure that they are safe, of sufficient quality and presented to consumers in ways that do not mislead. The regulator's job is then to hold those businesses to account for delivering their obligations. Such systems harness the fact that in an environment where customers – or patients in the case of dentistry – have a choice, treating them well is good for the business as well as good for the patient. We would like to explore the risks and benefits of applying this approach in dentistry, particularly as the shape of the sector continues to move in the direction of consolidation.

The legislative framework in which we operate hints at such mechanisms. Powers exist for the GDC to establish a register of corporate dental providers, although it has not been considered necessary to bring them fully into effect.

However, we also need to recognise that there is a wide range of business models within dentistry, from small practices owned by one person, to large corporate bodies running hundreds of practices of varying sizes across the country. We know that diversity in the business models across the sector has brought considerable investment and innovation into dentistry in the recent years.

We also know that a lot of good work is already being done across all kinds of practices and some of the corporate bodies to support the delivery of high standards of service and care, and to promote the values of professionalism among their workforce. In the first instance, therefore, we are looking to complement these initiatives by highlighting the important role of employers in delivering safe and high quality care. We propose to work with relevant stakeholders to redevelop our existing guidance for employers as a means of exploring the role that dental businesses have to play in ensuring a focus on patient protection and standards.

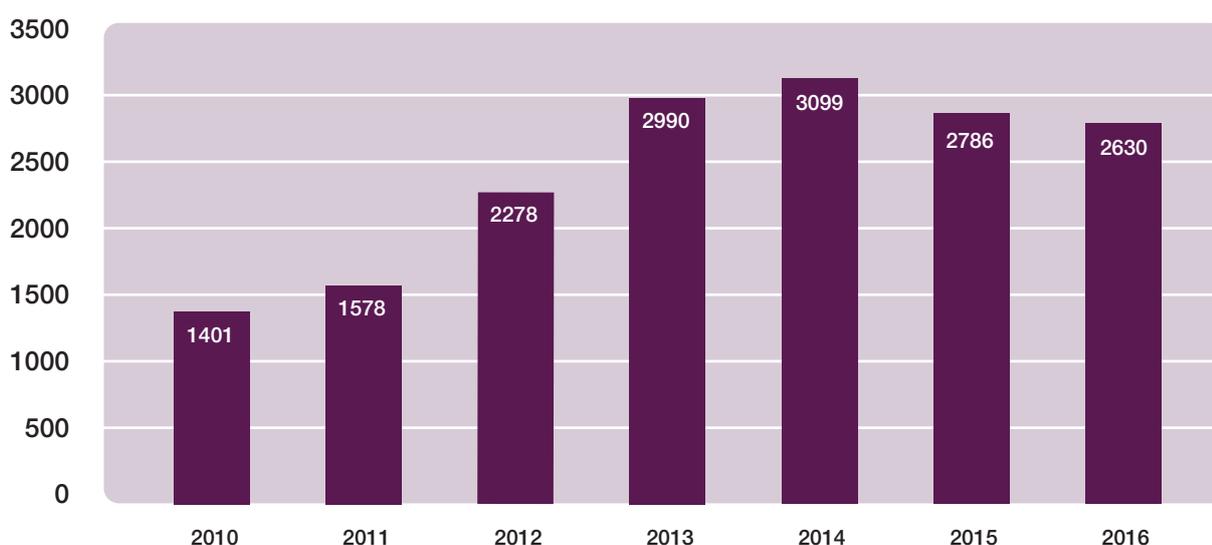
ACTION: GDC to further develop guidance for employers, reflecting the need for the employer to ensure that the *Standards for the Dental Team* are embedded within a professional's practice.

4. Re-focusing fitness to practise

The GDC's fitness to practise powers are an important part of our role in protecting patients and maintaining public confidence in dental services. As with any enforcement process, there are multiple stakeholders and numerous sensitivities which must be balanced, while pursuing our overarching objectives: protecting patients, and maintaining public confidence in the dental profession through upholding proper standards of conduct for members of those professions.

Society has seen sweeping changes over the decades since fitness to practise mechanisms were established, and the regulatory model that we and other healthcare regulators are required to adopt has not kept pace with these changes. The relationship between professionals and the public across all spheres of healthcare has changed radically. Developments in technology have given consumers access to information that was once reserved to experts, increased their expectations in terms of customer service, given them tools to compare experiences of services and to provide feedback, or to complain, more or less in real time. Developments in public service delivery have attempted to put patients – and consumers more widely – at the centre of services in a way that arguably gives them more control and power than has historically been the case. These and other factors mean that the volume and range of issues that the public raise about healthcare, including dentistry, have increased.

Figure 7: Graph showing annual numbers of fitness to practise referrals received by the GDC



Despite these changes, the tools made available to healthcare regulators to deal with this increased breadth and volume of cases have evolved very little in decades or more. Patients raise many issues, concerns, complaints and feedback about dental services for which our fitness to practise powers are not well suited. We need, working with the profession and partners, to develop ways of ensuring that these concerns can be appropriately raised and resolved, by the right body, at the right time and at the right cost.

Until wider legislative reform is secured our current fitness to practise powers will continue to play a very important role. In the meantime, our overall ambition for regulatory reform envisages a broadening of the range of tools available across the regulatory system, by working more closely with other organisations and the profession itself, which have access to alternative mechanisms. This plan depends in part on being much clearer about the issues for which fitness to practise powers are likely to offer the most appropriate solution, being more active in routing other matters elsewhere and, in order not to leave patients high and dry, helping them navigate the alternatives. The PSA's recent publication *Regulation Rethought*³⁶ is very strongly resonant with much of this thinking.

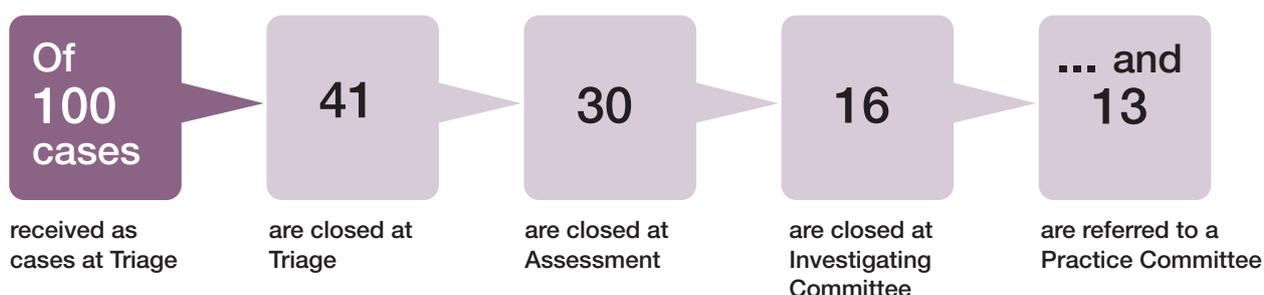
We have looked at our processes and have, in conjunction with some of our partners, developed a series of initiatives and proposals to address these issues. These initiatives are at varying stages of development, and we welcome feedback from the profession and our stakeholders on how we can translate these into action.

Fitness to practise: patient risk and public confidence

There are a number of statutory grounds of impaired fitness to practise, including misconduct, health and deficient professional performance. For the purposes of this document, we are focusing primarily on conduct and performance. The concept of 'impaired fitness to practise' embeds a notion of serious shortcomings in competence or conduct and the range of outcomes and sanctions available in response – advice, warning, undertaking, reprimand, conditions of practice, suspension and erasure – enable proportionate management of the risks posed by these shortcomings.

However, the overwhelming majority of complaints that reach the GDC do not require these sanctions. Based on current figures, more than 40% of matters raised with us are closed at the triage stage. A further 30% of cases received are closed at the next stage, assessment, meaning that more than 70% of the matters referred to us are not considered to be allegations of impaired fitness to practise and may be better resolved by other means.

Figure 8: Diagram showing the percentage of disposals at each stage of the fitness to practise process, 2015



Coupled with the fact that the processes prescribed in legislation can result in lengthy and often expensive investigations, even where sanctions are not ultimately applied, there is a strong sense on the part of the professions that the regulatory system is not treating registrants fairly and does not manage complainants' expectations. This has little to do with the effectiveness of our management of processes, where enormous – indeed transformational – improvements have been secured in recent times³⁷ – but rather with how we are currently required to deploy those processes, and our approach to determining whether a complaint or other information amounts to an allegation of impaired fitness to practise (with all the seriousness that entails).

There are difficult balances to be struck. First, we are subject to some legal constraints. The Dentists Act requires the Registrar to determine whether a complaint or other information amounts to an allegation of impaired fitness to practise. If it does, we are required to investigate. And of course, in any remodelled system we need to ensure that we remain capable of identifying those cases that we are under a statutory duty to deal with.

To address some of these issues, we have identified a number of actions, some of which are already underway at the GDC. We welcome feedback on any aspect, particularly the identified actions.

Public facing information

The information provided to members of the public is vital to increasing clarity and managing expectations in respect of the GDC's purpose and powers and processes, and the possible outcomes from the fitness to practise process. Many of the concerns currently raised with the GDC suggest the information currently available to the public is either not accessible, not accessed, or does not sufficiently clearly set out what they should expect when raising a concern with the GDC. This is not helpful for patients, registrants or the GDC. We therefore propose to review all our public information to improve clarity, manage expectations and assist members of the public in determining how and with which body to raise concerns. This review should ensure that information is provided in plain English, avoiding the use of terms not readily understood by those unfamiliar with professional regulation (e.g. fitness to practise).

³⁷ <http://www.professionalstandards.org.uk/docs/default-source/publications/performance-reviews/gdc-annual-review-of-performance-2015-16.pdf>

ACTION: GDC to review 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.

Stronger ‘front door’ mechanisms

Other mechanisms can be used to support this information and act as a pre-contact filter, particularly for website users. For example, a ‘self-filtering’ questionnaire, consisting of a small number of questions, before a web user can access the web form in order to raise a concern. There are a number of issues to consider when implementing mechanisms such as this, including the importance of not increasing barriers for informants raising concerns, and the GDC’s own drive to increase use of the web form. Having been introduced in 2015, the proportion of complaints received via the web form is significant but still relatively low (22%). This is the most efficient way for the GDC to receive fitness to practise concerns, and sets out clearly for users the information they need to provide, thus minimising the need to contact informants to request further information. We are therefore currently undertaking some work to increase use of this form and make it more accessible to web users.

Other regulators, including the General Pharmaceutical Council³⁸ and the General Medical Council³⁹, provide information and questions for website users who wish to raise a concern to explain the purpose of the fitness to practise process and to direct users to other bodies if their concern is not for the regulator.

The General Pharmaceutical Council website takes the user through a series of pages, from which they must confirm that they have read the material and believe their complaint is for the regulator, before they can access the web form to raise a concern.

The General Medical Council website poses a series of questions to website users, requiring them to confirm various matters, including their willingness to give consent, before allowing them to access the web form to raise a concern.

ACTION: GDC to implement online tools for ‘self-filtering’ of complaints, in line with other regulators.

Linking fitness to practise to patient protection and public confidence

Professional healthcare regulation has long been based on the concept of the ‘reputation of the profession’. This has arguably led regulators into territory – for example, questions of morality – where it is difficult to be clear about what matters, and in whose interest – the public’s or the profession’s – they are operating. The GDC’s current screening tests, at triage and assessment, ask decision-makers to consider whether damage has been – or might be – done to the ‘reputation of the profession’.

We want to explore how our own processes and information might better reflect a re-focused approach to fitness to practise. Our proposition is that fitness to practise matters beyond simple reputation of the profession (which arguably the profession is itself best placed to uphold) should be clearly linked to risk to individual patients, public confidence in dental services and/or maintaining proper professional standards and conduct: 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.

The GDC needs to continue to develop and calibrate our understanding of seriousness, and ensure that our own guidance material incorporates and embeds the importance of the application of the various statutory tests. While it is not possible to develop an exhaustive definition of serious misconduct, it is possible to improve the picture for decision makers of what serious misconduct looks like. Furthermore, it is possible, using the GDC’s own information and decisions from Practice Committees, to establish what those committees view as serious enough to result in a professional’s fitness to practise being impaired. We need to carefully consider the implications of this and how it would work in practice.

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.

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.

ACTION: GDC to review all guidance material for fitness to practise decision makers to ensure that seriousness is properly and fully embedded within it.

ACTION: GDC to carry out an end-to-end review of the fitness to practise process, involving stakeholders and partners.

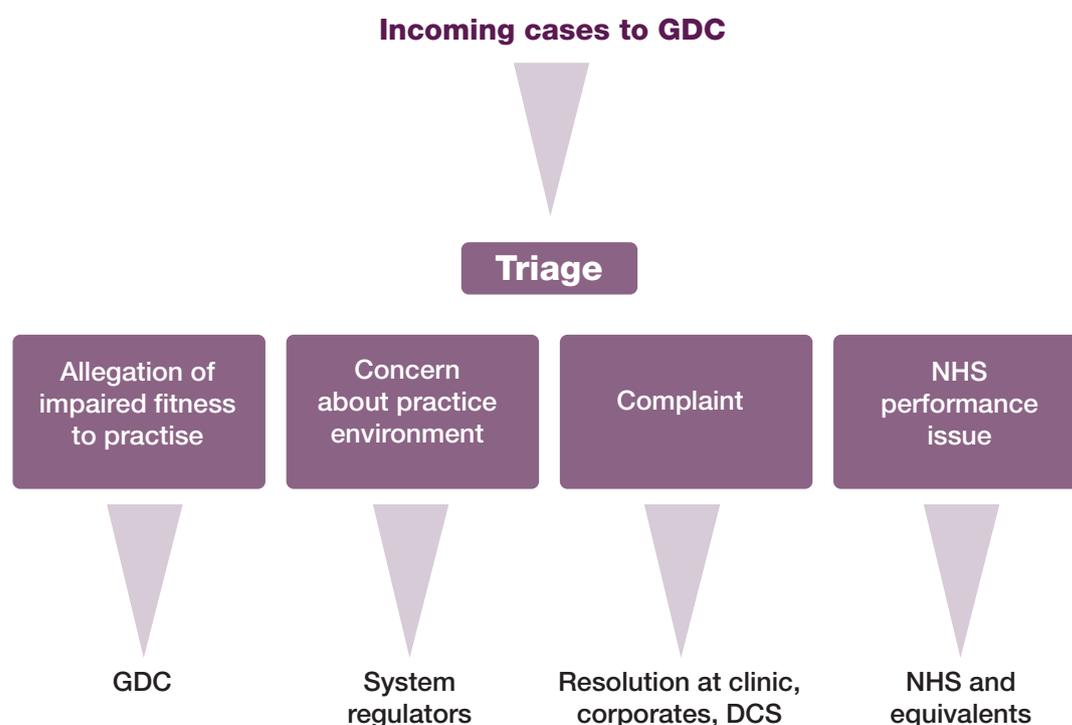
Redirection of cases that are not serious enough to invoke the fitness to practise process

Across the dental system are many bodies with various tools for dealing with a wide range of problems or concerns that might arise in connection with the delivery of dental services to patients, including: serious problems that might result in serious harm to patients, less serious questions of performance that nevertheless need to be addressed, and complaints about, for example, customer service. Those bodies include regulators (the GDC, CQC, NHS and equivalents in the different parts of the UK) educational structures (e.g. the Deaneries) the defence organisations and, of course, the profession itself, whether in the form of dental practices, larger dental businesses and the range of local professional networks in different forms throughout the country. We also run the Dental Complaints Service as a mediation service for complaints about private dental treatment.

There is scope to explore the extent to which we might drive a ‘virtual’ regulatory system by actively routing cases to the component of the system best placed to deal with them. This is not always easy for patients and the public to navigate, and to determine where best to raise their concern. The GDC’s power to prosecute professionals against whom there is an allegation of impairment should only be deployed in serious cases. Alongside working with our partners to ensure that cases are dealt with by the appropriate body, there is also work to be done to increase clarity and manage public expectation about the roles of the various bodies involved, and the possible outcomes.

This does not mean that individuals, particularly patients, should be left with unresolved concerns. Patients should be encouraged to resolve their concerns directly with the professional or the practice where possible (see section 2 on first-tier complaint resolution). Where this is not possible or not desirable, the principle should be that the issue is resolved using the lowest level of intervention needed to achieve the appropriate result.⁴⁰ For private patients this might mean a refund or an apology from the professional or the practice, which can be facilitated via the Dental Complaints Service. Some matters are best resolved via NHS performance management processes, and some concerns are best shared with systems regulators.

Figure 9: Model depicting appropriate routing of concerns and complaints about dental professionals



We have already begun to make progress in some of these areas. The GDC has, following a pilot period, recently implemented the NHS Concerns handling process in England. Under this scheme, matters raised with the GDC that are not serious enough to amount to an allegation of impaired fitness to practise are closed, with information being sent to the commissioner of the service (NHS England). The informant is notified of the closure and provided with information about the NHS complaints process, and is advised, in the first instance, to raise their concern with the practice. Proposals to put in place a similar scheme in respect of non-NHS dentistry are now being developed. Plans are also at the early stages of development in respect of similar schemes in Scotland, Wales and Northern Ireland. Work is underway, under the auspices of the Regulation of Dental Services Programme Board (RDSPB), to include the Care Quality Commission in these schemes, for matters that should be dealt with via their processes.

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.

Improved calibration of standards and application of tests

We recognise that many in the profession are concerned that the GDC's focus in relation to fitness to practise may have become too broad in recent years and has gone beyond those cases that raise a genuine and serious question about a registrant's current FtP. While the picture is complex, we do accept that we need to continue to develop our approach, and to do so in partnership with others.

Figure 10: Diagram showing the proportion of GDC registrants who are subject to sanctions following a fitness to practise referral



An allegation that a professional's fitness to practise is impaired on the basis of their conduct is, necessarily, an allegation of serious professional misconduct. The principle of proportionality is key to the fitness to practise process, and decision makers therefore need to assess whether the information made available to the GDC by an informant is evidence of a problem serious enough to amount to an allegation of impaired fitness to practise. The GDC needs to ensure that it calibrates its approach to determining which matters are sufficiently serious as to amount to an allegation that a professional's fitness to practise is impaired.

As set out above the GDC is working with partners to ensure that issues are dealt with by the right body, at the right time. These arrangements with our partners need to be kept under review to ensure that referrals made between bodies are appropriate, and that the organisations share a common view of how matters should be resolved and by whom.

A group, with representatives from each relevant organisation, should therefore be established with the purpose of ongoing calibration of external referral decisions, and providing feedback and learning to each organisation. We are currently working with NHS England to develop this model and propose to launch a calibration group early in 2017 which will consider types of cases referred to NHS England under the NHS concerns scheme. Any learning generated will be fed back to improve the function of the process. We will aim to extend the remit of such a calibration group, potentially to include health services in the other UK countries, private treatment, and treatment provided by corporate bodies.

ACTION: GDC to establish external calibration mechanisms with partners to ensure that concerns are being referred appropriately between bodies.

Building on principles: news steps

Many of the issues set out in this document are both important and complex. We think it is right to take the time to ensure that they are aired and discussed. We are publishing this document for a formal discussion period of three months, ending on 26th April 2017. We will collate and summarise the views we receive and publish a report setting out our plans. We are likely to wish to consult further on specific issues, for example in relation to CPD.

Fees

One area where we intend to consult as early as we can is the GDC's approach to setting fees. The current approach, which is based on detailed line-by-line analysis of the GDC's fixed operational budgets does not do enough to make clear the complexity of the dental regulatory system and the many factors that influence its cost. Nor does it encourage the development of partnership and leadership by all involved in the system, including the profession itself, with a clear focus on better public protection, fairness for registrants and improved cost effectiveness.

We therefore intend to consult on a new approach to fee setting in the first half of 2017.

Conclusion

The purpose of this document is to stimulate discussion and debate on how we can make professional dental regulation better for patients and fairer for dental professionals. The actions identified within it are fundamentally about shifting the balance in the way we regulate, from being a reactive regulator to one that works 'upstream' and in greater collaboration with all of our partners. In some areas, our proposals represent a significant but necessary departure from the way the GDC currently operates.

If we are to deliver the change that is needed and realise the benefits for patients and professionals of improved regulation, we need to develop a joint vision for the future. We cannot do this alone, we want to work with the profession and all our partners to achieve it. We need your help to build a system of regulation which is fair and proportionate and ultimately contributes to safe patient care in which the public rightly has confidence.

In order to develop that joint vision, we need to gather a range of views and establish a consensus about the change that is needed and how we can deliver it. We therefore invite you to consider what we have set out and tell us your views. You can engage with us by

Providing comments on our online form at www.gdc-uk.org

Emailing shiftingthebalance@gdc-uk.org

Using the hashtag [#shiftingthebalance](https://twitter.com/shiftingthebalance)

Proposals for action

We welcome comment and feedback on the proposals for action set out in this document, which we have listed below for ease of reference. The easiest way to respond is by completing the online form at www.gdc-uk.org or you can email your comments to shiftingthebalance@gdc-uk.org

Moving upstream

The proposals for action in this section are designed to enable us to move to a more supportive model of regulation, based on providing dental professionals with the information and tools they need to meet and maintain high professional standards. This relies on the GDC working with its partners and the professions to ensure that high standards are maintained, from pre-registration training onwards. There are three main elements to the upstream proposals: improving our engagement with professionals and embedding the standards, how we deploy our powers in relation to education, and continuing professional development (CPD).

Improving our engagement with professionals

- ▶ 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.
- ▶ 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.
- ▶ GDC to develop, as part of its engagement strategy, an annual 'state of the nation' report on dentistry.
- ▶ GDC to work in partnership with relevant bodies to develop methods of linking the standards to performance management and appraisal.
- ▶ 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.

Education

- ▶ GDC to devise a process to ensure that the learning outcomes are agile and responsive, and continue to be based on appropriate evidence.
- ▶ GDC to develop and adopt a risk-based quality assurance process for dental education, to be implemented in 2018-19.
- ▶ GDC to develop materials for registrants who have trained outside the UK to ease their transition into practising here.

Continuing professional development

- ▶ GDC to develop a model which encourages and enables professionals and professional bodies to take ownership of CPD planning, development and innovation.
- ▶ 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.
- ▶ GDC to incorporate an emphasis on interactive CPD into the developing model, and explore the risks and benefits of this.
- ▶ GDC to incorporate a significant peer review element into the developing model, and explore the risks and benefits of this.

First-tier complaints resolution

The actions in this section are designed to strengthen first-tier complaint resolution by supporting and enabling the professions to handle complaints well and build on existing good practice, and expand access to independent complaint resolution.

- ▶ 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.
- ▶ GDC to continue to develop a profession-wide complaints handling initiative to strengthen first-tier complaint resolution.
- ▶ 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.
- ▶ 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.
- ▶ 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.

Working with partners

The proposed actions in this section are designed to explore and establish the roles of the profession, employers and other key stakeholders in the broader system of regulation.

- ▶ 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’.
- ▶ 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.

Refocusing fitness to practise

The initiatives set out in this section are designed to ensure that we provide clear information to patients and the public about our powers and the system of regulation, and to ensure that we are deploying those powers proportionately and in line with our overarching objectives.

- ▶ 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.
- ▶ GDC to implement online tools for ‘self-filtering’ of complaints, in line with other regulators.
- ▶ 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.
- ▶ 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.
- ▶ GDC to review all guidance material for fitness to practise decision makers to ensure that seriousness is properly and fully embedded within it.
- ▶ GDC to carry out an end-to-end review of the fitness to practise process, involving stakeholders and partners.
- ▶ 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.
- ▶ GDC to establish external calibration mechanisms with partners to ensure that concerns are being referred appropriately between bodies.



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