BDA response to the Department of Health consultation ‘Promoting professionalism, reforming regulation’

January 2018

Introduction and overview

1. The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. BDA members are engaged in all aspects of dentistry including general practice, salaried primary care dental services, the armed forces, hospitals, academia and research, and our membership also includes dental students.

2. A review of regulation has been expected for a long time, and we welcome the Government considering reform. The BDA has long called for an overhaul of the healthcare regulatory system.

3. Our experience with the General Dental Council (GDC) illustrates the problematic issues with inflexible legislation and a lack of parliamentary time to consider necessary changes. This has contributed to the GDC's inability to deal in a timely way with a rise of issues (often referred to as 'complaints' but we believe this terminology is wrong) received in the fitness to practise section, not all of which needed to be opened as formal cases. However, the GDC has taken the view that the legislation obliged it to pursue all matters as a formal case. This resulted in a situation where many cases that should never have been considered before an FTP panel had to go through the full process, only to be concluded with no or little action. This in turn created excessive costs, loss of time and income for professionals, lack of clarity – and lack of access to dental care - for patients. In summary, an immensely stressful situation for all involved, and one which could and should have been avoided.

4. The way in which the regulator has been led and has previously interpreted its own legislation has certainly exacerbated the situation, and we have some comments to make about transparency and accountability below. However, it is clear that more flexible legislative structures would help to deal with issues in a more appropriate way.

5. We will be commenting on some of the proposals below. However, it needs to be recognised that this consultation document is lacking to a large extent in meaningful information on which clear comment could be based. There are many assumptions but few of these are backed up by clear data, with much of the data used having disclaimers attached. Comments to this consultation must be taken in that context. Any potential changes in the future must be subject to further formal consultation.
6. One issue that we would raise above all others is a very serious concern about the theme of workforce planning that emerges within this consultation, and the new role that seems to be assumed for regulators in this regard, almost as a side issue.

7. Regulators do not, and should not, have any role to play in workforce planning. Their role in law is the protection of the public by registering professionals with appropriate qualifications, overseeing education and taking action when professionals fall significantly below accepted standards. Professionals pay fees to the regulators to enable them to fulfil their role.

8. There cannot be a system where registration fees are used to pay for a system to help with workforce planning; this is a role for governments. Such an approach would clearly make the regulator a government department, while regulation is meant to be independent of government.

9. Regulators cannot be required to quality-assure the education of professionals and then use these powers to manipulate the workforce in line with Government priorities.

10. We call on the Department of Health to drop any suggestions that regulators have any kind of role to play in workforce planning. It would be an insurmountable conflict of interest.

11. We are concerned that, on a number of occasions, dentistry is left out of the list of currently registered professions with clear reasons for statutory regulation (see page 14 paragraph 2.1: “The case for regulating doctors, nurses, midwives and pharmacists on a statutory basis seems clear. For other professions, particularly new professions, the need for statutory regulation is less clear.”) More specifically, this is premised on the basis of the perceived risk of harm the regulated groups may create. This list is repeated at various points in the document. We assume that there are no current plans for the deregulation of dentists as this would presumably have been outlined in more detail in the consultation. However, we would have appreciated more care to be taken in the drafting; we would like confirmation that this is not a deliberate omission.

12. We are pleased to see a number of references to the fact that a ‘culture of blame’ and a ‘punitive approach’ need to be addressed in the current system. We agree that the “adversarial nature of the fitness to practise process and the way it has been applied by the GDC has indisputably affected the outlook and culture” of the GDC which affects the trust professionals have in it. We feel that, contrary to bullet point 1 on page 7, the public is actually well-protected from poor professional practice, certainly in dentistry. Where problems might arise is where the systems in which professionals work, in particular the current NHS dental contract in England, negatively affect the provision of care. We welcome references to more proportionate regulation and greater support for professionals in the delivery of high-quality care.

13. We have a number of concerns about the statistics used in the foreword and executive summary of the document. It seems to paint professional regulation in a deliberately negative light to suit some of the arguments made for change. We do not recognise some of the analysis and believe that if a direction of travel is decided upon based on this consultation then it will likely result in an unworkable system. While we would welcome cost reduction, this should not be at the expense of an even less workable system. As it stands, some of the potential outcomes of these proposals would lead to greater central control and de-professionalisation.
Consultation questions

Q1: Do you agree that the PSA should take on the role of advising the UK governments on which groups of healthcare professionals should be regulated?

14. This is a logical step as the PSA is the only organisation with an overview and suitable knowledge of health professions and has undertaken the work on right-touch regulation and on risk assessment. It therefore seems well-placed to take this work forward. However, there are a number of issues to be raised in conjunction with this proposal.

15. We would first refer to the PSA’s own response to the Department’s consultation on Medical Associate Professions, in which it states that the way in which the DH/HEE has used – and changed - the PSA’s system for right-touch assurance in that consultation is not how it was intended. Therefore, any recommendation for its use must ensure that the PSA’s framework is properly understood.

16. Secondly, much of the PSA’s work is currently paid for by contributions from the regulators, although there are certain exclusions. It would be inappropriate if regulated professions paid for assessments for additional professions to be regulated. This side of the PSA’s work would have to be financed by government, and be added to the list of exclusions.

Q2: What are your views on the criteria suggested by the PSA to assess the appropriate level of regulatory oversight required of various professional groups?

17. The criteria appear appropriate although there have been some minor changes to the list presented in the consultation as compared to the published assessment tool. The point about ‘risk perception’ is much more about public and stakeholder confidence than about confidence level for the relevant profession and could become a very subjective point. We would prefer a recognition of the fact that regulation is important to professions’ perception of their status based on their responsibilities and the public confidence that is linked to this. However, the PSA’s stance that regulation is not about the enhancement of status for professions creates a problematic dissonance in this consultation.

18. The detail on how this would be used and any assessment and changes would have to be subject to further consultation.

Q3: Do you agree that the current statutorily regulated professions should be subject to a reassessment to determine the most appropriate level of statutory oversight? Which groups should be reassessed as a priority? Why?

19. Yes, we believe that there could be merit in reassessing some currently-regulated professions. In dentistry, there are questions about the wisdom of the statutory regulation of dental nurses and dental technicians. It is clear that a number of registered dental nurses and technicians, often in the hospital or community setting but also in general dental practice, have increased their scope of practice to a point where their risk assessment will be higher than for those who undertake routine support work for dentists in the surgery but do not use extended skills. On the other hand, there are serious recruitment issues in dental nursing, and drop-out rates in training are relatively high; we also hear reports of issues with compliance with CPD requirements and re-registration problems in these groups particularly. Using the PSA’s two stage risk assessment criteria (2.5 and 2.6) it is hard to see how chair side dental nurses and dental technicians would need to be regulated.
20. While initially supportive of the concept of registration of these groups, the BDA is now not convinced that statutory registration for dental nurses and technicians has benefited the majority of individuals in these professional groups since it was brought in between 2006-2008, and a reassessment of this policy would be welcome. A removal of statutory regulation might also help with recruitment issues into these professions. There would be a need for different risk assessments for those working within the basic scope of practice and those using extended duties.

21. We are aware that the discontinuation of registration of these groups would reduce the size of the General Dental Council’s register considerably and would affect the composition of the Council, or potentially place it into a situation where it was regarded a likely candidate for amalgamation by the Department. The BDA is supportive of the retention of a dental-specific regulator, but it should be on the basis of adequate risk assessment, not on the basis of number of registrants. In other words, we do not agree with the premise in the consultation that a regulator which oversees a small number of registrants is fundamentally unviable and needs to be amalgamated. Please see additional comments on this in later sections.

Q4: What are your views on the use of prohibition orders as an alternative to statutory regulation for some groups of professionals?

22. We do not have any specific expertise on the use of prohibition orders in this context or how they would work given that some form of a ‘negative register’ would presumably need to be held, with related cost implications.

23. We are, however, aware that it has sometimes been difficult to clarify whether a certain procedure is the ‘practice of dentistry’ whilst other individuals, whether regulated or not, believe they are carrying out a procedure that is either medical or “just” cosmetic. Tooth whitening currently and tooth jewellery in the past are examples of this, the number of prosecutions for illegal tooth whitening provision by non-registrants has increased significantly since tooth whitening was explicitly defined in law as the practice of dentistry.

24. There are a number of other clinical areas where individuals, sometimes registered, sometimes not, perform procedures that should be recorded as illegal practice. We are very concerned, for example, about recent increases in the use of ‘tongue tie release’ in newborn babies. This often seems to be performed on the basis of little or inappropriate training, even though individuals might be registered in a healthcare professional category. An inappropriate use of the procedure can have serious negative results for the patient; it should only be performed by a suitably qualified registered clinician, working with other professionals in the appropriate setting, after a full diagnosis and with full information for – and consent by – the parents.

25. Whether prohibition orders would be useful in this context we do not know. In general terms, a clearly defined regulatory system without additional options for decision-making is preferable.

Q5: Do you agree that there should be fewer regulatory bodies?

26. We do not feel that it is for us to comment on the number of regulators as such; the cost of regulation falls to the different professional groups that are regulated, and while a streamlining of some powers might seem desirable, this could be achieved by changing and aligning relevant wording in legislation rather than discontinuing regulators. We are not sure that there is any evidence to suggest that costs of regulation would be reduced significantly with a reduction in the number of regulators, or that there is any evidence to justify a reduction in regulator numbers. We cannot necessarily see that an efficiency
kicks in when a regulatory body has a registrant base of between 100,000 and 200,000. The GDC has 108,209 registrants; 66,099 (2015 figures) of these are DCPs. We would argue that even if chairside dental nurses and dental technicians were no longer registered with the GDC this would not automatically make it an inefficient or expensive organisation to run though we have concerns about the GDC’s unexplained reasons to have a large cash reserve.

27. We support the retention of a dental-specific regulator in principle, despite our concerns about the GDC’s performance in the last few years. The profession of dentistry is different to other professions in many ways in terms of the breadth of the training and the career pathways, the way in which care is delivered in different settings, and the way professionals work in the NHS as well as on a private basis. The business arrangements and costs to the end user and the mixing of NHS and private treatment on the same patient is unique to primary dental care provision. An understanding of these issues is important so that the regulator for dentists is aware of how decisions it takes will affect the profession, and thus the delivery of dental care.

28. Dentistry is much more than ‘drilling and filling’. A dentist’s training mirrors in many ways the undergraduate training of medical doctors and the prescribing rights that dentists reflect this. Many health conditions manifest themselves in the mouth or are linked with oral health (diabetes, heart disease, smoking) and oral health is an intrinsic part of general health and wellbeing. However, the provision of services is different. Therefore, we believe there is a need for a dental-specific regulator which is led by individuals with in-depth knowledge of the dental profession; and are very clear that the Chair of the dental regulator should be a dentist. Dental regulation currently suffers as a consequence of having a Chair who does not understand the profession.

29. Professionals have a strong interest in being regulated appropriately, and by that we mean that the fundamental points of regulation are fulfilled – keeping a register of only those with appropriate qualifications, setting and quality-assuring a training, education and standards framework, and taking action when serious breaches of standards occur. This is how patients are protected best – by the profession working with and having trust in the regulator to ensure that those on the register are well-qualified, follow appropriate standards, and that problems are addressed.

Q6: What do you think would be the advantages and disadvantages of having fewer professional regulators?

30. We realise that there is an assumption at the Department of Health that an amalgamation of regulators would lead to economies of scale and streamlined procedures. We are not convinced that there is evidence that costs would necessarily reduce, however. The fixed costs form a small percentage of the total expenditure of the regulators so at best only marginal efficiencies are likely to be achieved. The consultation document does not provide a sufficiently detailed analysis of the necessary factors.

31. It needs to be remembered that some of the inefficiencies of regulators have their cause in existing legislation which has prevented them from improving their processes in a timely way. Changing the number of regulators will not in itself address the problem, and it might not be a necessary step if other issues are addressed.

32. The effect on morale of those professions who feel they will have lost their identity will be larger than the Department might anticipate.

33. As outlined earlier, the BDA supports the retention of a dental regulator appropriately fulfilling its statutory roles. If the GDC were to be disbanded or merged, we could only see dentists being regulated by a regulator with responsibility for both dentistry and medicine.
We believe that suggestions of a ‘high street’ regulator are inappropriate particularly
given the breadth of dentistry and specialisation in the profession. Suggestions that
regulation of dentists could work in line with the HCPC has also found no support from the
profession. The HCPC or the NMC could potentially take on the regulation of existing DCP
categories, however, in the event of a reduction of regulators.

34. There may well be merit in close working relationships between the regulators on some of
the administrative procedures. However, education, training, CPD and fitness-to-practise
would clearly require proper dental expertise.

35. This dental expertise would need to ensure that a relatively small profession such as
dentists is not ‘forgotten’ within a bigger entity such as the GMC. The GMC’s approach to
revalidation would not work in dentistry, for example, so different, diverging policies would
still be necessary.

36. A “one-size-fits-all” approach must be avoided, as it will not work and will be detrimental
to all concerned. As a consequence, any potential economy of scale savings are further
brought into question.

37. In summary, we are not convinced that suggested changes would be workable, or that
there would be significant cost savings from this. The existing professionals would still
need to be regulated somehow, so a smaller number of big regulators will be regulating
many different groups of registrants with different skill sets and competencies while
trying to work with – and support – several hundred thousand registrants. This would also
mean that apparent improved engagement between government and these bigger
regulatory entities might not be as straightforward as assumed in this consultation.

Q7: Do you have views on how the regulators could be configured if they are reduced in number?

38. There is too little information in this document to form a view. As mentioned earlier, many
issues could be resolved by changes to legislation rather than a reconfiguration that
would be costly and might not work.

39. We are however concerned that there may be an appetite at the DH to move forward
with this idea as it is such a focus of the consultation. Therefore we would have to say
here that, if the GDC were to be disbanded or amalgamated, dentists should be regulated
alongside doctors. Professionals should be regulated on the basis of ‘what they do’, in
other words, on their level of risk (and not on where their perceived place of work is). There
is no support amongst the dental profession to be regulated in line with so-called “high-
street professions” through amalgamation with the HCPC or the General Pharmaceutical
Council, although some of the dental care professional groups could possibly be registered
with the HCPC or the NMC. While dentistry is often delivered through similar
arrangements in high-street practice as some other professions, the training, risk
assessment and responsibility show that dentists are more closely related to doctors; they
diagnose, inject, cut and medicate. Many dentists are also working in the hospital sector
or the community, mirroring the terms and conditions of the medical model, or in research
or academic roles at universities.

40. Another option would be an overarching body with sections for all regulated professions,
as introduced in Australia in 2010. The system has seen some streamlining of approach
and has had some positive effects of reducing a double-jeopardy in the regulatory system
for dually-registered professionals, but it has not resulted in cost reductions and there
have been struggles with appropriate expertise and understanding of the professions at
times.
41. We support clearer registration and regulation of non-clinical (practice) managers and employers within the healthcare system.

Q8: Do you agree that all regulatory bodies should be given a full range of powers for resolving fitness to practise cases?

42. Yes. BDA hospital dentist members have experience of improved local resolution approaches in recent times through the GMC procedures. They have noticed increases in the number of requests to respond to GMC preliminary enquiries, but these have led to some early closure of matters that might have gone to FTP in the past.

43. We welcome references to the need for an improvement in supporting registrants who are faced by fitness-to-practise procedures. For several years now, registrants have felt ‘guilty until proven innocent’, and the stress levels in the profession are continuously on the rise. [See BDA research into stress and burnout]

44. The dental profession has clearly suffered by adversarial procedures and lengthy timescales in the fitness-to-practise area. Some of this has been addressed in recent times through internal changes at the GDC and the introduction of Case Examiners (CE) and also clinical dental advisers; and the changes are slowly filtering through, with improving figures in the number of cases resolved at CE stage without the need to refer to a Practice Committee as well as timescales improving somewhat.

45. The ‘dispute resolution’ issue is somewhat problematic in dentistry, however. ‘Complaints handling’ should not be the role of regulators, and while there has been the ‘Dental Complaints Service’ in dentistry for just over 10 years, there have been problems with its approach in recent years. We believe that complaint resolution must be separate from the regulator under all circumstances. There must furthermore always be a focus on local resolution.

Q9: What are your views on the role of mediation in the fitness to practise process?

46. The term ‘mediation’ is not defined in this consultation in relation to fitness-to-practise except in the context of making the investigation of the case more ‘inquisitorial than adversarial’. While we acknowledge that making the process less adversarial will be welcome, we must however say that mediation has no role in the fitness-to-practise process, which is, as the name suggests, about the fitness to practise of a registrant. Mediation and dispute resolution can be used as part of complaints handling, for example if there has been a difference of opinion on specific aspects, such as cost or choice, but it is fundamentally different from a registrant’s fitness to practise. Mediation must under all circumstances be separate from the regulators, otherwise neither patients nor professionals will trust the process.

47. In addition, mediation can be costly, and can be offered through different service providers who specialise in dispute resolution. Registration fees should not be used for this.

48. In dentistry, the Dental Complaints Service (DCS) has been in existence for 10 years as an arms-length body from the GDC that has focused on private dental complaints. We are concerned for the reasons outlined above that this service seems to be brought in-house this year by the GDC.
Q10: Do you agree that the PSA’s standards should place less emphasis on the fitness to practise performance?

49. No, it should remain a central aspect; in fact, the central aspect. Our experience with the GDC in the recent past was that this was the main bulk of the PSA’s work in highlighting how badly the system was performing, and led to much-needed improvements. There is a separate question about whether the PSA’s measurement of FTP processes focuses on the right issues.

Q11: Do you agree that the PSA should retain its powers to appeal regulators’ fitness to practise decisions to the relevant court, where it is considered the original decision is not adequate to protect the public?

50. In recent times, this has been a relatively small issue in dentistry, suggesting that FTP panels usually make the right decision. However, we would say that if FTP processes were managed properly in the first place there would be no need for such reviews, and that ideally the FTP panel system, including an opportunity to appeal, should suffice.

51. There have been few, possibly no, reviews by the PSA into cases where the outcome might have been too stringent; in a truly fair process, this would also need to be taken into account, and not just those decisions that are “unduly lenient”, as does the effect on the registrant.

52. We have no strong opinion on the retention of these powers either way; however, we are aware that other professions believe that this process is costly and not particularly fair.

Q12: Do you think the regulators have a role in supporting professionalism and if so how can regulators better support registrants to meet and retain professional standards?

53. We do believe that regulators have a role in supporting professionalism, but the drive, the necessary information and any guidance must come from the (relevant) profession. Regulators already support professionalism by developing education curricula, quality assurance, guidance on Student Fitness to Practise and standards guidance.

54. Regulators – especially if led by ‘lay’ individuals – should not be able to dabble in the detail of professional development. The Pearson report, reviewing appraisal and revalidation in medicine, showed that while revalidation was working, it had also significantly increased the administrative burden on doctors and that further support was necessary. The GMC is working to improve its system but within dentistry the appraisal-based approach would not work due to the different ways in which dentists work.

55. It must not be forgotten that medical revalidation is funded by the Department in England – more stringent systems for dentists would need to receive the same support. It would also mean even more time away from clinical practice and active patient care. The administrative system around medical revalidation also does not work for general practice dentistry.

56. Nevertheless, we support the ‘upstream’ approach for peer review as long as this term (peer review) is not equated with appraisal, i.e. performance management. In dentistry, these are two decidedly different things. The recognition by the GDC in recent times that a new approach was needed and that that needed to include support for professionals and a better way for local complaint resolution and learning from complaints is welcome if it continues in a reasonable way. A regulator working well with the profession is the best way forward for supporting professionals in the provision of care.
57. We take very serious issue with paragraph 3.30. Focusing on England, this paragraph seems to include the definition of the role of Health Education England as that of the regulators. HEE itself is a problematic entity and is at this moment considering extremely questionable and ill-informed changes to dental training. HEE is the wrong organisation for this project in the first place and the outcomes are likely to be biased and detrimental to dental training and therefore patient care. Quality-assurance of undergraduate dental education and training is a core function of the regulators; workforce considerations are absolutely not.

Q13: Do you agree that the regulators should work more closely together? Why?

58. If this could lead to a better approach to integrated care then there might be some positive consequences. We could potentially see that a single register could be developed, although the PSA already provides a search function for all the registers, which might suffice – the funding for registration aspects would have to be discussed.

59. The example of the Regulation of Dental Services Programme Board in England, a co-operation between GDC, CQC, NHS England, BSA and Healthwatch, has provided some good ideas for the future and the model of cooperation, once settled in, was a good one. However, there, as everywhere, the issue of appropriate funding for dental services was a problem that continued to be highlighted. The profession cannot continue to do ever more for less. The BDA calls on the Department of Health that whatever comes out of this consultation is supported by appropriate funding mechanisms for all professions.

Q14: Do you think the areas suggested above are the right ones to encourage joint working? How would those contribute to improve patient protection? Are there any other areas where joint working would be beneficial?

60. A standards framework would have to be very generic, with specificities for all the professions. A single adjudicator would need to have expertise in all the professions, and a single back-office function would need to be limited to the work that does not require professional expertise. In England, the Care Quality Commission (CQC) already has some fundamental standards of care that work across professions, and there may not be a need for more streamlining. There should be no additional administrative or financial burden for professionals. There is also a danger of unintended consequences and problems in the development which would need to be mitigated.

61. In terms of improvements in patient protection, the changes would probably be minimal. A different register and an amalgamated back-office function might help with information to the public in some respects. Given that a standards framework would have to be generic and an adjudicator would have to have expertise in all healthcare branches, the argument for patient protection does not seem to be a particularly strong one – and neither is that for cost reduction.

Q15: Do you agree that data sharing between healthcare regulators including systems regulators could help identify potential harm earlier?

62. We would generally support a data sharing approach which is in the best interest of avoiding harm. However, in dentistry we have had very serious issues with a ‘triple jeopardy’ approach through our regulatory system. In England, a single patient complaint could lead to investigations by the GDC, the CQC and the NHS. Even if there was no case to answer, all three regulatory entities would have become active, with huge costs to the individual as well as the public, and with no particularly positive outcome for the patient. The GDC, CQC and NHSE have recently worked together under the ‘Regulation of Dental
Services Programme Board’ with one intended outcome being the sharing of data so that the most appropriate authority investigates an issue. We would be concerned if this consultation advocated a return to the dangers of triple jeopardy; it would be devastating for professionals.

63. The Department of Health should also consider the implications of the new General Data Protection Regulation as part of this approach.

Q16: Do you agree that the regulatory bodies should be given greater flexibility to set their own operating procedures?

64. The GDC is already able to set certain of its own operating procedures, and there have been a number of situations in recent times where the lack of parliamentary time – or the willingness of those in government or the civil service to seek it – made it impossible for important section 60 orders to move forward, leading to a dire situation that could have been avoided had better processes been given the necessary support at the time.

65. Another major problem has been that there is little transparency or accountability for the GDC’s actions at the moment. Our most recent exchange of letters with the Chair of the GDC illustrates the problem well. The Chair makes assertions about the GDC’s accountability. However, it is clear that (in this instance) the GDC set a budget for work for which the costs were not publicly outlined, paid for by its registrants. At some time after setting the budget (just under a year), it will lay annual reports and accounts before the Westminster Parliament (and for information to the parliamentary institutions in the devolved countries). The accounts are audited and signed off, and approved by Parliament through an administrative procedure. However, there is no real scrutiny of how the money is being used and whether the decisions of how the money is used are appropriate and in line with the GDC’s fees policy; we believe they are not.

66. The profession has financed significant improvements in the fitness-to-practise area. The new procedures should no longer need the same level of ‘seed’ funding as they did in 2015. There seems to have been no government scrutiny over the appropriate use of registrant money. The profession is not supportive of the level of finance given to certain GDC projects if they are based on the same level as that over which the BDA fought a court case in 2014 – and won.

67. If the dental profession had trust in its regulator then the situation might be different. However, we have over five years of experience of how the accountability of the GDC does not work.

68. Concerns we have raised with the Secretary of State over the aptitude of the current Chair for this role has been met by government with suggestions we should “address our concerns to the Privy Council”, while the Secretary of State for Health is in effect the ‘Privy Council member’ for this purpose. The National Audit Office is not interested as the GDC is not a public body. So the appropriate use of registrants’ money is never checked. To us, this is poor accountability, and we feel that this lack of accountability must be addressed before rights for more flexibility in determining operating procedures can be granted to the GDC.

Q17: Do you agree that the regulatory bodies should be more accountable to the Scottish Parliament, the National Assembly for Wales and the Northern Irish Assembly, in addition to the UK Parliament?

69. We believe that the UK Parliament should retain overall control of the legislation that affects the regulators covering the whole of the UK; we would not wish to see a divergence in regulatory legislation as this would not be good for patients or
professionals; neither would it be cost-effective. It is worth noting that the dissatisfaction with the GDC in recent years has manifested itself in some calls for more localised regulation, including devolved nation level regulators in some cases, however.

70. We have no particular issue with the steps outlined in point 4.17 in relation to the provision of annual reports and accountability hearings to the devolved nation parliaments/assemblies.

Q18: Do you agree that the councils of the regulatory bodies should be changed so that they comprise of both non-executive and executive members?

71. As outlined earlier, the composition of the Council and particularly the appointment and re-appointment of the current Chair have been major issues for the dental profession. There have been issues both with accountability, as outlined above, and with transparency. We had to ask to be able to provide feedback during the reappointment process for the Chair despite a public announcement that third-party feedback would be sought. We do not know if this feedback was passed on to the Privy Council at the time.

72. We do remain concerned by the negative attitude to aspects of ‘self-regulation’ in this document, as we believe some of the changes that have been made under the guise of ‘independent regulation’ have been detrimental to patient care. This is because professionals who are more aware of their status take pride in their work and are critical of individuals who jeopardise this. We realise that self-regulation is not likely to return but would wish to highlight that, contrary to some assertions, it was not a system that was detrimental to patient care; the actions of those whose cases led to the changes were appropriately dealt with as criminal.

73. We have no particular comment about the non-executive and executive members of the Council, other than to say that it is not clear from the consultation document which role these members would have; for example, would everybody have the right to vote? We have experience of a Council with a lack of knowledge of the profession it regulates. We would oppose any efforts to change the constitution of Councils further to include a higher proportion of ‘lay’ members. The Chair of the GDC should be a registered dentist for reasons outlined in point 28.

74. On another matter, the profession does not believe that appointment by the Privy Council shows independence from government.

Q19: Do you think that the views of employers should be better reflected on the councils of the regulatory bodies, and how might this be achieved?

75. No, we do not think that the views of employers should be reflected on councils at all. As employers’ focus is first and foremost on financing a service and possibly a business, this would be a major conflict of interest and would be detrimental to independent regulation and to patient care. It must also be remembered that in some professions, such as dentistry, the majority of dentist registrants are not actually employed, but independent contractors.

76. Paragraph 4.23 is again completely unacceptable. Regulators do not have a role in ensuring ‘the right workforce’.
Q20: Should each regulatory body be asked to set out proposals about how they will ensure they produce and sustain fit to practise and fit for purpose professionals?

77. It is core business for regulators to be concerned with the fitness to practise of their registrants, through education, training, and continuing professional development. We are not sure how exactly a ‘fitness for purpose’ is ensured – is this meant to be in line with a registrant’s scope of practice?

78. We reiterate our strong and unequivocal opposition to any kind for role for the regulator in workforce planning.

Q21: Should potential savings generated through the reforms be passed back as fee reductions, be invested upstream to support professionalism, or both? Are there other areas where potential savings should be reinvested?

79. We believe that all savings should come back to the registrants by way of fee reductions. However, we are not convinced that there will be any, and we would be interested to see more information on how the professions could actually judge which savings had been made, given our current distrust of governance arrangements. As previously indicated, the fees level for dentists have caused particular anger within the profession.

Q22: How will the proposed changes affect the costs or benefits for your organisation or those you represent?
- an increase  - a decrease  - stay the same

Please explain your answer and provide an estimate of impact if possible.

80. As outlined earlier, we are not convinced that the rather positive picture painted of cost saving will actually become the reality. We would welcome sight of the relevant evidence base. In relation to benefits, we cannot comment on these on the basis of the information provided in the consultation. We would also reiterate the need to delete any references to workforce planning from this review of regulation.

81. The main issue for us is appropriate regulation by a dentally-knowledgeable body which charges an appropriate fee for the work it does in the four areas of registration, education quality assurance, standards, and fitness to practise, and does not attempt to extend its remit beyond this or try to fulfil personal policies detrimental to the profession(s) being regulated.

82. The proposals in this consultation are not actually clear enough to provide a detailed answer; there would be a need for proper independent research followed by properly costed proposals which would then need to be consulted upon, but also bearing in mind that consultation needs to be undertaken at a formative stage. Some of the assertions in this document seem to be made without proper evidence, which raises concerns over which decisions have already been made. A full, proper and transparent cost-benefit analysis must be provided.

Q23: How will the proposed changes contribute to improved public protection and patient safety (health benefits) and how could this be measured?

83. Improvements in the fitness-to-practise area will clearly be welcomed by patients and the profession. We are not confident that there will be any other benefits or healthcare
improvements based on the assumptions in this consultation document, there is too little
detail to comment, it is too complex an area, and there is too little evidence as opposed to
assumption presented in the document.

84. The changes may well also lead to confusion amongst patients and the public if the lines
are blurred between the different professions and their responsibilities.

Q24: Do you think that any of the proposals would help achieve any of the following aims:
- Eliminating discrimination, harassment, victimisation and any other conduct that is prohibited
  by or under the Equality Act 2010 and Section 75(1) and (2) of the Northern Ireland Act 1998?
- Advancing equality of opportunity between persons who share a relevant protected
  characteristic and persons who do not share it?
- Fostering good relations between persons who share a relevant protected characteristic and
  persons who do not share it?
If yes, could the proposals be changed so that they are more effective?
If not, please explain what effect you think the proposals will have and whether you think the
proposals should be changed so that they would help achieve those aims?

85. We have no comments on this point.