BDA
British Dental Association

Mr William Moyes
Chair
General Dental Council
37 Wimpole Street
London
W1G 8DQ

1 April 2016

Dear Mr Moyes

I am writing with reference to your recent article in the Probe magazine (*'A new era of dental regulation'*, 10 March 2016).

From the outset, we would like to say that we welcome your long overdue comments about the GDC needing to get its house in order, and to work to restore the trust of the profession and to work in a synergistic way.

We also welcome the comments about the fact that you cannot "*improve quality through fear, and that the system is too heavily skewed towards sanction and away from what I think we would all want, which is learning*". We have made comments along these lines in our response to the GDC's consultation on case examiners.

We have chosen to write to you, therefore, about comments in the same article which we find highly contentious and which have the effect of significantly diminishing the intended message.

First and foremost, you make this assertion:
"It is worth remembering that the Council referred to in the report is not the Council that oversaw the whistleblowing incident. The investigation carried out by the PSA predates the appointment of the current Council and it is the current Council that has overseen the eradication of the unacceptable practises in the management of fitness to practise cases."

We believe that this is a misrepresentation of the facts. The PSA report itself indicates that the initial disclosure of concerns about objectionable practices in the FTP department was made on 31 July 2013, two months before the new Council took up its work (but certainly after your appointment in May 2013; the appointment of the other members was confirmed in early August 2013). The Pennington investigation into the matter was set up in August 2013. On 4 September 2013, it is noted that you as the incoming Chair of Council were informed that the disclosure had been made and an investigation would take place.

Everything thereafter – ongoing questions and concerns, the complaint by the whistleblower that they were suffering detriment, and indeed the PSA investigation that culminated with the current report, all took place after 1 October 2013, and therefore after the new Council was in post.

The PSA clearly states in the introduction to its report that it took the decision to investigate the whistleblowing incident on 11 April 2014, seven months into the tenure of the new Council. The same, current, Council, of course, in the end also oversaw the work that helped to eradicate the objectionable practices as you say; but much of the criticism that is part of this report clearly falls into the tenure of the current Council.

The previous Council was the focus of the 2013 report and it has been made clear that lessons were not learned from that report by either the previous or current Council, but the whistleblowing report fairly and squarely sits within the responsibility of the current Council.

We therefore ask you to urgently retract any statements made by you to the effect that the current Council was not the same as the Council that oversaw the whistleblowing incident. While we are aware that the Council has been thorough in considering the recommendations of the PSA report in depth and has approved a detailed action plan, a statement like the quote above puts into question all the reflection of the Council that has taken place and does absolutely nothing to restore the confidence of the profession in the Council.

Elsewhere in the article, you state that the PSA report has 'generated misunderstanding'. We are not quite sure what 'misunderstanding' has been generated; indeed, reaction to the report has been fairly clear and unanimous.

We also note in particular the following points that you raise in the article.

1. *"We also need to understand why complaints about dentists more than doubled between 2010 and 2014 – a far faster rate of increase than for doctors or nurses and midwives;*
2. *why a higher proportion of dentists are subject to a complaint than is the case for doctors and nurses and midwives;*
3. *and why there is really no system of clinical governance for dentistry to challenge bad practice and to provide a local mechanism for quickly dealing with a patient's dissatisfaction before it becomes a full-blown fitness to practise complaint."*

We would wish to provide the following comments in relation to these points.

Point 1:

- We have repeatedly said that the statements you make about the numbers of complaints do not seem to be based on proper evidence; you will remember your assertions during the Malcolm Pendlebury Lecture in 2014, when you stated that a 'crude' assessment of all

complaints to NHS England, DCS, CQC, Ombudsman and GDC "*could mean that 17 per cent of the profession were the subject of some form of complaint*". The assertion caused an outcry at the time, and the GDC's own figures certainly tell a different story. We ask you to provide sound evidence for your assertion, or to stop making this claim.

- It would be helpful if you could provide us with the evidence that it is actually the case that complaints against dentists have increased at a faster rate than for doctors or nurses and midwives. We have seen a GMC report which shows that FTP 'enquiries' had around doubled between 2007-2012, so not a particularly faster rate.
- Please also note the terminology of 'enquiries' rather than 'complaints'. The GDC's own figures over the last year with improved protocols show that many 'enquiries' to the GDC's FTP section do not lead to further investigations. We are therefore concerned that by framing your comments in this way you are prejudicing how these apparent figures are then considered by others.
- In addition to the much-quoted reasons of a more litigious public and the rise of no-win-no-fees lawyers, we believe this is partly due to NHS England cuts which have meant that they are not dealing with complaints in the same way they used to; for example, there was a complaints manager in most PCTs who dealt with many issues. We have the impression that complaints can be sent straight to the GDC because sufficient resources are not available at local level. There is some work currently ongoing in considering complaints at this level, of which you will be aware.
- The recession might also play a part, in that patients and dentists are under more financial pressure and dentistry is a paid-for service.

Point 2

- Again, first of all, please provide the evidence that this is true.
- One area that could explain high numbers is the fact that general dental practitioners of course charge for their services and are obliged to collect NHS charges, so many complaints are likely to be about value for money or possibly unreasonable patient expectation, rather than issues with the dentist's competence or behaviour. While these are issues that need to be considered, the place for them should certainly not be the GDC's FTP function.
- The number of dentists being erased is only slightly higher now than 5 or 10 years ago (14 in 2008, 16 in 2015), but the number of dentists on the register has risen significantly in that time, and most cases are resolved by conditions and suspensions. Therefore, the proportion of the profession that is so bad that it warrants erasure from the register is tiny, and even adding all the cases of conditions and suspensions to it, the proportion of the profession ending up before a panel is still very, very small (in 2015, 0.6% of dentists had an IOC or practice committee consider their case).

Point 3

- We agree that complaints should be dealt with at local level. There is a need for dental practices to comply with NHS contract requirements on clinical governance and related regulations, although the monitoring of this is different than it has been, due to the changes in the NHS system. Dentists also have to comply with CQC and equivalent organisations' requirements, which is part of clinical governance in a different way.
- NHS England's predecessors used dental practice advisers who would identify problems and help solve them – this system was reduced and the profession has lamented this, and has supported a similar procedure being introduced by CQC. The other UK countries have their own systems. In relation to complaints, the NHS GDS contract in England stipulates a need of having a complaints procedure in place that complies with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
- We are very concerned by the use of the word 'dissatisfaction'. The GDC is not a patient satisfaction policing authority. We have also repeatedly highlighted, including at the regulation event you refer to in your article, that the use of the term 'fitness to practise complaint' causes misleading statements and misunderstandings. In making statements about 'complaints', you should clarify whether you mean any contact from the public that comes to the FTP section of the GDC, or a contact that subsequently becomes an FTP case. Please consider the terminology you use to comply with the GDC's promises of 'fairness'.

In summary, while we appreciate the Council's detailed consideration of the recent PSA report, we believe that your comments suggest a continued lack of insight into what is necessary to move forward from a bleak period, in particular since the current Council took office. It makes it difficult to consider reassurances along the lines of 'restoring confidence by the profession' as anything but lip service.

We look forward to your comments and to receiving any evidence to illustrate your assertions.

Yours sincerely

Dr Mick Armstrong
Chair
BDA Principal Executive Committee