BRITISH ASSOCIATION OF PRIVATE DENTISTRY
Nicholas House, River Front, Enfield EN1 3FG

8th October 2020

Mr Ian Brack, Chief Executive and Registrar
Mr Gurvinder Soomal, Executive Director
Mr John Cullinane, Executive Director
Ms Lisa Marie Williams, Executive Director
Ms Sarah Keyes, Executive Director
Mr Stefan Czerniawski, Executive Director
General Dental Council
37 Wimpole Street
London W1G 8DQ

Dear Mr Brack, Mr Soomal, Mr Cullinane, Ms Williams, Ms Keyes and Mr Czerniawski,

We write on behalf of the members of the British Association of Private Dentistry (BAPD) in addition to the thousands of people who supported our petition, which forms a significant portion of the contents of this communication.

It is felt that the GDC has misjudged aspects of its engagement with the dental profession during recent years. This alienation of the very profession the GDC has been tasked to regulate has mirrored the tenure of your current Chair, Dr William Moyes, and would appear to be related to his own strategic lead, foretold within his Malcolm Pendlebury Memorial Lecture (2014) (See Appendix 1) and his subsequent failure to resign after the 2015 PSA report into GDC whistleblowing. Indeed, the PSA stated that Dr Moyes failed to grasp the significance, and the seriousness, of the concerns raised by the whistleblower with regard to the GDC's Investigating Committee's processes. Many would consider that these, as well as other shortcomings, should have led to his immediate resignation.

It is clear that Dr Moyes' lack of relevant dental experience influenced his wide shortcomings highlighted within the PSA report. Furthermore, it is probable that a registered dental professional would have been more suitably equipped to gauge the

gravity of the whistleblowing at a far earlier stage, with far less damage to the standing of the GDC within both the dental profession and the wider general public.

The PSA report can be accessed here:

https://www.professionalstandards.org.uk/publications/detail/report-of-investigation-of-general-dental-council-whistleblower-s-complaint

We understand that Dr Moyes has confirmed that his tenure as Chair will cease on 30th September 2021. We would suggest that the next Chair be selected from a shortlist of dental professionals and that the person selected would be working as a dental professional up to and including the selection period. To support this suggestion, we would draw your attention to our recent petition on 'change.org', which can be accessed here:

http://chng.it/qkTK6Yfv

The petition illustrates the strength of feeling within the dental profession that the selection and appointment process for the second appointed Chair of the GDC should include the requirement that all selected individuals must be registered dental professionals during the process. Whilst this petition provides material evidence of the need for change, for background it is important that we now examine in detail the selection process for the appointment of Dr Moyes in 2013.

The Privy Council had approved the appointment of the new Chair of the GDC, to take office on 1st October 2013. The Privy Council had been advised by the PSA on 13th May 2013, that it could have confidence in the appointment process. A pdf entitled, '*Good practice in making council appointments: Principles, guidance and the scrutiny process,'* can be accessed here:

https://www.professionalstandards.org.uk/what-we-do/our-work-with-regulators/appointments-to-councils

Specifically, the PSA stated that all elements of the appointment process met its four principles of a good appointments process i.e. *merit, fairness, transparency/openness and inspiring confidence*.

It is very clear when looking at the fourth principle, "*inspiring confidence"*, that the level of confidence regarding the appointment process within the dental profession was rapidly eroded by the performance of Dr Moyes in the role. It is vital that the subsequent appointment process has a central tenet of restoring the confidence of the dental profession in its regulator; only by a dental professional taking the Chair can this be achieved.

We will now refer to the specific actions of the GDC Governance Reforms Task & Finish Group during 2012, which are pertinent to Dr Moyes appointment.

In August 2012 the GDC Council considered recommendations on the appointment process and a recommendation on the composition of the selection panel members who would select the appointed Chair of the GDC. The GDC Governance Reforms Task & Finish Group recommended that an independent advisor should be appointed to make recommendations on the criteria required for selection of panel members. In November 2012 Ms Stella Panterlides was appointed to this role. The aim was to provide the appropriate level of distance for the GDC Executive during the selection panel recruitment process.

Subsequently, in December 2012, she provided advice to the GDC Governance Reforms Task & Finish Group, on the criteria for the selection panel for the appointment of the chair of the GDC. On the basis of that advice, it determined five distinct tenets for the selection panel selection process and member characteristics. We will enumerate these below:

1. Panel members must have a thorough understanding of what will be required of the newly appointed Chair and members in order to deliver a patient-focused corporate strategy, enhance the organisational effectiveness of the GDC, satisfy the regulators and inspire the confidence of the public and of key interested parties.

2. The make-up of the selection panels must reflect the diversity of the modern UK to be credible with stakeholders and candidates.

3. The Chair(s) of the selection panels will have a non-executive/advisory portfolio comparable to that of other panel members, but in addition, will have experience of having led high profile appointments.

4. To safeguard the independence of the process Council members will not be eligible to become members of the selection panels.

5. Chairs and CEOs of other health regulators will be excluded from panel membership in order to address the concern of potential conflicts of interest. The Group was keen to broaden out the definition of ‘regulatory experience’ to include systems regulators and those outside of health regulation.

In January 2013 selection panel members were identified and the GDC Chief Executive approved the final list on the basis of confirmation by Ms Stella Pantelides, the independent advisor, that the individuals met the five agreed criteria.

The four selection panel members are listed here:

Ms Elizabeth McMeikan (Chair)
Mr Graham Ball
Dame Patricia Hodgson
Ms Heather Lawrence OBE

We will now review the five criteria with regard to the appointment of Dr Moyes.

Regarding point 1, it is rather surprising that the dental profession is not mentioned by name as a key interested party. We are sure that you would accept that a GDC Chair should inspire the confidence of the very profession that they regulate? It seems logical that a Chair who fails to inspire that confidence will lead to the erosion of trust between dental professionals and the GDC, and this can only lead to a deterioration in overarching patient care parameters. We would submit that this is indeed what has happened during Dr Moyes' tenure.

Regarding point 2, we would suggest that the four selected panel members do not provide a reflection of the diversity of the modern UK. This calls into question whether this point was included for political expediency rather than a genuine attempt to meet its stated aim?

Moving to point 3, we would accept that these criteria were satisfied.

Regarding point 4, this aim is appropriate; however it could be considered to raise the issue of a perceived conflict of interest between Ms Heather Lawrence OBE and Dr William Moyes. As Chief Executive of Chelsea and Westminster Hospital NHS Foundation Trust, Ms Lawence had regular direct contact with senior executive members of Monitor, including Dr Moyes, their Executive Chair, where performance criteria for the trust were reviewed and targets agreed. Furthermore, Ms Lawrence followed Dr Moyes to Monitor as a Non-Executive Director in July 2012, after his departure in 2010. In view of this, we would question the appropriateness of her inclusion within a selection panel.

Moving to point 5, this appears to confirm the overarching premise for GDC selection at this time. Specific exclusion of selection panel members with health regulatory experience seems to confirm that a systems regulatory appointment was favoured with the formal decision to exclude health regulatory experience from both selectors or those selected. This appears to suggest inherent bias against the regulated regulating themselves, in the form of an appropriately dentally qualified Chair.

In closing, we have described a flawed process that led to the appointment of an individual, Dr Moyes, who did not perform adequately in this vital role. This has led directly to an unprecedented erosion of trust in the GDC within the dental profession. The restoration of this trust is fundamental to the future operation of the GDC as a successful 'Right Touch' regulator. To restore trust, we feel that the Chair of the Council should be someone who

has experience of being regulated by the GDC, in order to properly inform decisions and ensure they are made transparently.

As our petition demonstrates, the inherent bias, flawed selection panel selection process, and disastrous appointment to the GDC Chair will not be accepted should the process be repeated.

Your duty as a regulator is to protect the public, and we politely submit that in order to achieve this, a dental professional should be the Chair of the GDC. We have copied this correspondence to The Privy Council and PSA, since they are central to the appointment process for the new Chair at the end of September 2021.

We would put it to you that upon reflection you will recognise the need for an urgent action plan to put right the wrongs of the 2013 appointment process and that this should be made public without delay.

Yours sincerely,

Jason Smithson
Bertrand Napier
Simon Thackeray
Rahul Doshi
Victoria Holden
Dominic O'Hooley
Nav Khaira
Zaki Kanaan
Mel Currie
Stephen Jacobs
Tif Qureshi
Wayne Williams
Rachel Derby

On behalf of the members of the British Association of Private Dentistry.

CC PSA
Privy Council

Appendix 1

FINAL PENDLEBURY LECTURE JUNE 2014

INTRODUCTION

Thank you very much for inviting me to give this lecture.

I – obviously – didn't know Malcolm Pendlebury. Since I had no connection to dentistry before taking on the chairmanship of the GDC, and have had no professional reason to spend much time in the East Midlands, our paths never crossed.

However, I have read the obituary of him that the British Dental Journal printed in April 2005. It paints a picture of a man immersed in dentistry – not just treating patients, although clearly he did a lot of that in general practice and as a specialist at Queen's in Nottingham, but also a leader in developing education and vocational training, in setting standards and quality assurance systems and generally spreading the message that constant improvement is a key element of professionalism. The obituary concluded: "....he sought to raise the status of general dental practitioners, provide them with standards they could aspire to and thereby to raise the quality of patient care."
The challenges that Malcolm Pendlebury identified and tried to tackle have become more pressing in the ten years since his death. How to define service quality and clinical outcome, how to regulate the providers of services and who should do so, how to meet the legitimate expectation of patients that they will be treated with respect and not be damaged by the care they receive – all these questions and more are now at the forefront of the debate about healthcare.

As a relative newcomer to both the dental sector and professional regulation, four things seem clear to me:
1. The exposure of failure and bad performance will not reduce, it will increase. And the volume and intensity of patients' complaints about quality and safety is also unlikely to reduce very much, if at all, although it may fluctuate;
2. The GDC, like all professional regulators, will continue to be under strong and growing pressure to tackle more fitness to practise cases, faster and to come down harder on unsafe or poor quality care, or unacceptable behaviour; and
3. A concerted effort is required by the sector itself and by its various regulators and commissioners to prevent fitness to practise cases arising and to give patients better information about the performance of individual practitioners and better and faster redress mechanisms. A fitness to practise case shouldn't be the only remedy on offer, or even the most common one.
4. Service users will become increasingly consumerist in their outlook – many already are - and so the pressure will not lessen for services to be designed around the needs of patients and for care to be delivered in ways that patients are happy with. If anything, it will increase.

WHY WILL THE EXPOSURE OF FAILURE GROW?

Why do I say that the exposure of failure will continue to grow? The main reason is a change in attitude on the part of politicians and the public.
Since the creation of the NHS successive governments have tried to find ways to improve efficiency and productivity across the NHS. Beveridge's assumption that the NHS would be increasingly affordable as a healthier population required less care quickly proved to be completely false. The demand for all forms of healthcare has grown well beyond anything that might have been expected and shows no sign of slackening. Different forms of central planning and direction have made no real impact.
Most recently the Blair and Cameron reforms to the organisation and functioning of the NHS in England have been designed to bring market pressures to bear by:
giving patients increasingly wide choice of where and how they are treated
setting performance targets for services
developing funding mechanisms that (supposedly) reward increased activity – attracting more patients – and penalise failure to attract patients
tougher regulation and inspection
greater transparency about service quality and clinical outcome.

The main focus has been on hospitals, especially acute hospitals. Dentistry has not been centre stage. Indeed dentistry already operates in a market. Patients are free to choose their dentist. Roughly half of the dental sector's income comes from private payments, not general taxation. To a reasonably large extent the success or failure of a dental practice depends on it serving its patients well. I know that not everyone likes or accepts the proposition that dental service providers compete in a market place, but that is the reality and increasingly it is the viewpoint of patients.
However, dentistry has not been unaffected by the development of a quasi- market in the wider healthcare system and will not be in the future. Why?
Markets produce failures as well as successes. Indeed, for a market to function properly customers have to be aware of whether a provider is good or bad. So, it was, and remains, a central objective of policy that the customers for different healthcare services should be able to make rational choices, based on reliable information about the quality of performance of different providers. In other words, for the policy to work Ministers have had to acknowledge - indeed, publicise - failings in clinical and service quality – some of which were highlighted by the targets set by government.

Simon Stevens, in his recent speech to the NHS Confederation's annual conference highlighted the importance of publishing reliable and easily- accessible data on clinical performance. Not for the first time most effort is focussed on acute hospital care. But, in time this will become routine in every part of the English healthcare system, I believe. Already there are several social media sites where patients offer their own, often

highly-subjective, assessment of the quality of care they have received. So, it would be foolish to think that the information revolution will pass by dentistry.
Even today the exposure of failure has had an impact on dentistry as well as on teaching hospitals and DGHs. Today media stories about healthcare, including dentistry, are as likely to be about failings as successes. Politicians and the media are prepared to criticise the healthcare system in a way that would have been unthinkable a decade ago.
This pressure to expose failure in all its forms will not reduce in the future. Indeed, the financial pressures that lie ahead for the healthcare sector may well increase the risk of bad practice and poor treatment.
The case for protecting the funding of the NHS is increasingly questioned. As the economy grows, so too will the funding of the healthcare system.....probably. However, we won't see repeated the scale of increase in funding of the early part of this century.

If additional funding is forthcoming, acute hospitals are likely to continue to absorb a growing proportion of the available money. There will also be new priorities to accommodate. For example, ministers are increasingly emphasising the need to support the funding of social care from the NHS budget, and to give mental health a degree of protection.

Somewhere in the system funding will be squeezed. It seems unlikely that dentistry will escape. But a squeeze on funding can create unforeseen incentives to take risks – to cut corners in diagnosis or treatment, to use cheaper materials, to spend less time per patient, to avoid investing in new equipment or in maintaining premises, and so on. These are precisely the kinds of behaviour that generate complaints to the GDC and other regulators about fitness to practise.

DEMAND FOR DENTISTRY IS GROWING...AND SO ARE COMPLAINTS

Public attitudes have also changed. The users of dental services are now much more consumerist in their attitude. Dentists and dental care professionals now have customers, not clients .....or, indeed, patients. Part of a consumerist attitude is an expectation that services will be organised around my needs and preferences, that quality will be good and the price fair. And if the service is poor or the quality unacceptable, consumers are willing to complain and to seek whatever form of redress seems appropriate to the circumstances of the case.
These consumer pressures are compounded by the increase in demand for dental treatment, and in the volume of complaints. 1.4 million more people have been seen by an NHS dentist since 2010. Not all of this is traditional oral healthcare work. Demand for cosmetic treatments continues to rise - there has been a 50% rise in cosmetic dentistry in the past 5 years
So, this increase in demand for services coupled with changing attitudes have together generated an unforeseen level of complaints. There has been a 110% increase in

complaints to the GDC between 2010 and 2014. Well over half of our budget is spent on fitness to practise.
And it's not just the GDC that is getting more complaints about dentists and dental care professionals.

It is extremely difficult to get a completely accurate picture of dental complaints across the UK as it isn't centrally recorded. But in 2012-13:-
NHS England received 7637 complaints about primary and secondary dental care
The Dental Complaints Service dealt with 1876 cases
The CQC received 1043 complaints
The Ombudsman investigated 3770 NHS health complaints, some of which would have included dentistry (but there's no breakdown of the figure to help us)
Add to these figures the 2972 complaints made direct to the GDC.
In 2013 there were just over 38500 dentists and 62500 dental care professionals on the GDC's register. So very crudely – and I stress that caveat - these very rough figures could mean that 17 per cent of the profession were the subject of some form of complaint. Even allowing for some overlap between the referrals to different agencies, this is staggeringly high.

It also undermines somewhat the proposition that there is a high level of patient satisfaction with dentistry.
Bear in mind that the GDC doesn't aggressively market its disciplinary role.....we don't behave like a claims management company! However, the Francis report said regulators should raise their profile with patients and engage in more pro-active regulation. The GDC can't ignore that.

All of us – we and you and the other professional bodies - need to understand better what is causing this apparently high and growing level of complaint, and what can be done. Perhaps we should meet to pool intelligence and to identify areas for research or further analysis.

THE GOVERNMENT WANTS BETTER AND FASTER REGULATION.....THE GDC IS UNDER PRESSURE

My second theme tonight is the need to recognise that the regulators themselves are not immune from scrutiny. We are under pressure.
A big part of the focus of the Francis inquiry into Mid-Staffs was on actual and potential failings in the overall regulatory system – both professional and system regulators. The Healthcare Commission (now CQC), Monitor, the GMC, the NMC were all criticised to different extents.
And even before the Francis report was published and the Government started to think about its response, it was becoming increasingly clear that, despite a sophisticated system of commissioning and regulation, Mid-Staffs was not unique in mistreating patients and

delivering care of an unacceptably poor standard. The Government realised with some shock that poor professional performance was being unearthed in many parts of the healthcare system. This was – and is - a bigger problem than just Mid-Staffs.
As a result the political and media focus was, and remains, as much on the performance of the regulators as on the performance of clinicians.

So, the Government wants better – tougher and faster - regulation. The following quote from the Government's response to the Francis report in March 2013 illustrates this.
".....where standards are not met, the health and care system must be quick to detect problems, take robust action and hold those who are responsible, to account"
A regulator must be seen to act. Any delay or hesitation leads politicians to question whether the public can have confidence in the regulator..... which, of course tends to undermine public confidence!
But, there is, I think, confusion in the minds of politicians and the public – and certainly the media - about whether good professional regulation is intended to punish registrants for past failures, or to establish that registrants have changed their behaviour or improved their skills – or are willing and able to do so under supervision – so that they are fit to practice again either now or in the near future. That's an issue that needs further exploration.

So, this is the era of conspicuous regulation, when rapid and tough intervention by a regulator, with maximum transparency and publicity, is the expected response to any failure in the healthcare system. And, of course, there are many occasions when that is a reasonable expectation.

THE IMPLICATIONS FOR THE REGULATION OF DENTAL SERVICES

What does this mean for dental regulation?
The GDC has to respond. Our system of regulation has to be, and be seen to be:
focussed on protecting patients;
able to respond quickly, and fairly, to all kinds of allegation of bad practice or bad behaviour on the part of professionals; and
capable of reaching sensible conclusions about increasingly complex issues.
However, we operate in a complex regulatory environment, with different organisations policing different, but sometimes overlapping, parts of the healthcare system. For example, both CQC and the GDC regulate dentistry, and the MHRA regulates medical devices and the HSE can have a role in policing safety issues such as radiography. No doubt there are other bodies which might have roles in specific types of case – fraud, for example.
So, the GDC needs to be clear about its role and responsibilities, although these are nowhere defined very clearly so far as I can establish.
My current view is that the GDC's responsibilities might be defined as:-
to protect patients from harm;
to enable patients to get effective redress when harm occurs;

to enable patients to secure high-quality care and effective treatment at a fair cost;
to help the profession to be more responsive to patients and to offer effective services efficiently; and
to meet current requirements for professional regulation (as defined by the Government, the devolved administrations and the Professional

Standards Authority) and to help these bodies to develop regulatory standards and regimes.

This isn't very different to the obituarist's summary of Malcolm Pendlebury's professional ambitions, although perhaps more prosaically expressed.

If this is indeed a correct formulation of the mission of the GDC, everything we do should be determined by it, and we should do everything we reasonably can to achieve these purposes. I want to spend a few minutes summarising our current activities and future plans to discharge this remit.

However, we mustn't lose sight of the fact that the GDC is only one of several actors on this stage. Dental care, like most sectors of healthcare, is part of a system in which different elements – policy makers, commissioners, regulators and service providers – have distinct but complementary parts to play in the organisation, delivery and oversight of good and improving care. The dental professions, and, indeed, patients, have big roles to play and I want to say more about this before I conclude.

Fitness to practise reforms

Returning for the moment to the GDC, undoubtedly the Council's first priority for 2014 is to strengthen our fitness to practise regime. And we have already made a good start. While the decisions taken by the panels are judged by the Professional Standards Authority to be generally sound, we know from the audits undertaken by the Authority that our basic administration has been sloppy – poor communication, inadequate record keeping, deadlines missed etc. Part of the reason has been poor training and supervision of the staff. That is being sorted.

Part of the reason has been excessive caseloads. By investing in new teams to clear the growing backlog of cases, we have also managed to reduce caseloads to an efficient level. Already the benefits are clear. We are also using our technology better to manage processes – to ensure deadlines are met and communication happens.

Each of these is a small thing in itself, but in total they will create - are creating - better, more efficient processes that will enable us to offer a better service to patients and to registrants. The recruitment of an expanded pool of IC panel members and the creation of a much stronger support function for the panels will also play a big part in improving our performance in this area.

One consequence of this scale of investment is that fees will rise, probably substantially. And they need to keep pace with the increasing volume and cost of fitness to practise

cases, although the GDC is no more immune to pressures on its costs than any other public body.
However, all that said, the legislative framework within which we currently operate is badly in need of a complete overhaul. It's disappointing that the Government will not introduce in this session of Parliament the draft Bill produced at its request by the Law Commission. A huge amount of time and energy has gone into developing that draft legislation. I hope it hasn't been wasted. But I am clear that the bulk of the reforms it would have created will not happen in my term of office in the GDC. We will lobby hard to rescue what we can from it. Any help you can offer will be gratefully received!
However, fitness to practise should not be the main means of tackling under- performance and patients' dissatisfaction. In many cases a lengthy and complex process dominated by lawyers, over which the patient can exert almost no influence, is not what aggrieved patients want. They want an apology (probably) and they want deficient dentistry put right, which in some cases means funding to seek treatment from a different practitioner. This is what the Dental Complaints Service offers, and it does so remarkably successfully. It's fast, it's cheap and complaining patents and registrants are both very satisfied with the results it achieves.

But, it's available only to private patients.

My aspiration is to extend the work of the DCS to include patients funded by the NHS. As well as giving a better service to patients who seek personal redress and to registrants whose professional work is generally acceptable in quality but has failed in a specific incidence, making the simpler and faster and cheaper processes operated by the DCS much more available ought to reduce the current high level of expenditure on fitness to practise.

In addition to these internal process reforms the GDC is developing a strong working relationship with the CQC. Information is being exchanged, areas of risk are being identified and each regulator is gradually influencing the approach of the other. I am confident that this process will continue, to the benefit of both bodies. We aim to secure a similarly close relationship with NHS England, particularly under Simon Steven's inspiring leadership. Securing close coordination of the specification and commissioning of services, system regulation and professional regulation will be beneficial to both the dental professions and also to the users of dental services. But, it's work in progress.
Two other issues on our agenda deserve to be mentioned.

First, Continuing Professional Development. We attach importance to the registrants we regulate keeping up with developments in their fields, adding to their knowledge of their subject and related disciplines and learning new skills and techniques. But, it feels to me intellectually unsatisfactory for the regulator to focus on the volume of CPD undertaken by different dental professionals and not to pay some attention to the quality of the CPD products on offer and the effectiveness with which they are delivered. Can it really be left to

individual registrants to assess the quality and relevance of the wide range of CPD now on offer? Shouldn't the regulator, or the professional bodies, develop a better means of identifying CPD products that will genuinely improve the quality of dental care? I don't pretend we have specific plans. But this feels to me an area where not everything that should be done has been done.

Second, standards. As someone new to the field, I find the GDC's standards impressive – clear, pertinent, covering all the main issues, not over-prescriptive. We know that a majority of registrants are aware of the standards, and that they get referred to for guidance in dealing with specific issues that arise in practice. However, our research suggests that knowledge and use of the standards is by no means universal in the profession. That concerns me. It raises in my mind the question whether the GDC should make a more explicit link between securing registration – the right to practice dental care – and reliable evidence of knowledge and use of the standards.
Our registration system puts a lot of effort into establishing the qualifications of an applicant at the point of first registration, and rightly so. But, if we share Malcolm Pendlebury's stated aim of a high-status, high-standards profession, shouldn't we use the levers available to us to ensure that the standards we have developed are properly understood by all registrants? It a thought I leave with you tonight, but one I hope we might return to in the future.

A stronger focus on patients
A few moments ago when I was talking about the GDC's responsibilities the first thing I mentioned was protecting patients from harm. We need to develop a better understanding of what those words mean in practice to patients. There is little point in us pursuing programmes of action that patients think are irrelevant to their needs and aspirations. So, in thinking about our future strategy, the GDC's starting point will be to develop a better understanding of the perspective and priorities of patients.
The research we have done to date paints a confusing picture.
96% patients claim to be "satisfied" with their dental treatment. But they have no clear idea of what might constitute quality of service or of treatment. And, underneath the surface, there is evidence that the apparently high level of patient satisfaction is wide but not deep.

So what drives patient satisfaction with their care and treatment?
Patients described a good dentist as being one who had excellent communication skills, talked through the treatment that they are having, were polite and treated them with respect. Trust that the patients' interest is put first is also key.
Qualitative research the GDC carried out in 2013 suggested that for many patients their satisfaction derives more from assumptions they have made rather than firm evidence. Patients assume that regulation is more extensive, unified and patient-centred than those of us involved may believe to be the case in practice. Patients are often poorly informed about the role of the GDC, but expect a proactive approach to regulation. They assume that we and other regulators actively search for consistent signs of poor care or malpractice, and expect evidence of problems to be proactively followed up without the need for a

dis-satisfied patient to lodge a formal complaint. In our focus groups patients emphasised the importance of regular, unannounced OFSTED or mystery shopping-style inspections, which should focus on all aspects of quality dental care. And they were keen on star ratings being applied to dental practices.

Patients had specific views about the type of information that would support them in making choices and acting as informed consumers. They want to understand issues such as how good their treatment is and how safe their dental professional is.

Of course, not all patients had identical expectations and attitudes. There was a continuum. At one end were patients characterised as having a traditional outlook – they assumed that all dental services were of a similar quality and so they tended to base their choice of provider on convenience; they were unlikely to complain, except where they received very poor care.

At the other end were patients with a strong consumerist outlook who were likely to be more active and demanding. They would compare dental treatment and shop around. They were much more likely to complain and to provide feedback and they were consistently the most likely to be positive about increasing patient choice.

Many patients were in the middle of this continuum and exhibited attitudes and behaviour drawn from both types, but would be likely to be more demanding when circumstances changed (moving to a new area and choosing a new practice).

We will continue to research the attitudes of patients. In addition we are launching an online patients' panel. The three main objectives of this are;

1. To provide evidence about public views and perceptions of topical or current issues in dental regulation
2. To provide public and patient views on their experience of the quality of dental services
3. To obtain public and patient feedback about regulatory policy initiatives or communications being developed or recently undertaken by the GDC.

I hope that this will broaden and deepen our understanding of the perspectives of different types of patient, and guide us in developing strategies driven by what patients need and want.

I also hope that we, and NHS England and the devolved administrations, and perhaps the profession itself can develop sources of information that patients can use to make well-based choices. One sure way to reduce the growth in fitness to practise cases is for patients to be able to choose where and how they are treated based on reliable and easily-understood information about issues such as quality of service, appropriateness and effectiveness of clinical treatment, likely cost. Enabling potential service users to avoid weak practitioners before damage is done is surely a lot better - and cheaper - rather than prosecuting a fitness to practise case after the event.

THE CONTRIBUTION OF THE PROFESSION

I've talked in some detail about what the GDC is doing and what we aspire to do and achieve. And I've also talked a little about the role that patients can play in incentivising registrants to deliver high-quality care and treatment, given easy access to good and relevant information. What can the profession, and bodies like the Faculty do both to improve standards and prevent the continued growth in fitness to practise?

I don't have a to-do list for you. That wouldn't be inappropriate. But, taking as a starting point the aspirations of Malcolm Pendlebury, as his obituary summarised them, I think I can be expected to pose some questions for your consideration.

First, does the public, especially users of dental care services, understand what you do to protect them and to promote better and safer care? Is there more that you can do – in concert perhaps with us and others – to educate potential users of dental care services about what level of quality and safety they are entitled to expect? About what "good" and "excellent" mean?

Second, how can you help us prevent the growth in fitness to practise? How can you help to get our standards understood and used by all registrants? If that were achieved, if our standards were internalised and put fully into practice, many complaints would be dealt with in the practice and not in a GDC hearings suite.

Third, can we work together to understand better what patients want from dental care and why they feel it is necessary to complain? Can we, and other bodies, join forces to develop a common understanding of the reasons for different categories of complaint and to understand how the need for complaints might be prevented?

Finally, CPD. How can you help to ensure that what is on offer is of high- quality and genuinely improves the knowledge or skills of registrants? This seems to me a key issue for the profession to tackle, with every encouragement from the GDC.

CONCLUSION

Mr Chairman, once again my thanks for inviting me to give this address. If nothing else I have found it extremely helpful as a means of getting my own thoughts in some kind of order, although I would be the first to acknowledge that I have much to learn. I hope, however, it has been of some interest to you and your colleagues tonight. And I hope it has helped to illustrate that the agenda that Malcolm Pendlebury pursued throughout his professional life remains as relevant today as it was ten years ago.