THE UNIVERSITY OF WINCHESTER

Evaluation of Remediation Support in UK Dentistry

Prepared for the General Dental Council

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Contents

Table and graph index

Executive summary

Summary of research

The General Dental Council (GDC) is the regulator of dental professionals in the United Kingdom (UK). All dentists and Dental Care Professionals (DCPs) (i.e. dental nurses, dental technicians, clinical dental technicians, dental hygienists, dental therapists and orthodontic therapists) must be registered with the GDC in order to practise in the UK. The GDC has a statutory responsibility to protect patients.

If a dental professional has performance issues, remedial action may be required to support that individual in order to keep them in practice. Remediation is defined as "*supervising and monitoring the implementation of the individual practitioner's strategy to redress the aspects of underperformance identified and agreed by the detection, diagnosis and assessment processes"* (Tackling Concerns Locally, 2009, pg. 58).

It has been reported in the literature that complaints about registrants with performance concerns are increasingly being made to the GDC (Pearce *et al* 2015). The GDC has reported a 31% increase in cases received between 2012 and 2013 (GDC, 2014). In addition there has been an increase in the number of cases referred from the Investigating Committee to a Practice Committee (GDC, 2014). Consequently it may be concluded that the demand for effective remediation support is similarly growing.

The GDC commissioned this research to assess and evaluate the remediation services currently provided in the UK, in order to understand if the current supply and approach is likely to be adequate in supporting any potential future scheme of continuing assurance of fitness to practise (revalidation). The research questions for the evaluation to explore were:

1. What types of remediation support activities exist for all forms of dental practice?
2. Why do dentists and DCPs access such support?
3. How do dentists and DCPs access remediation?
4. What are the main costs associated with provision and participation in remediation support and who bears the costs?
5. How do remediation services positively contribute to supporting dental professionals to keep on track?

Method

This was a mixed methods evaluation, combining both qualitative and quantitative data, derived from three stages of research:

- stage 1: Initial scoping
- stage 2: Data collection
- stage 3: Analysis and reporting.

The aim of stage one was to define what was meant by 'remediation services', and to establish the current suppliers of remediation services for dentists and DCPs across the UK. In preparation for stage two, keywords and exclusions or limitations to the search criteria were defined. A data extraction template was developed to capture the key points of information identified in the next stage, to ensure comparability across all types of documents and data included in the review. In addition to this, the research team made contact with key organisations and individuals within the remediation network. The purpose of this stage was to build knowledge and establish organisations to target for stage two.

Data was collected in stage two using three different data collection techniques;

1. literature review
2. survey of suppliers of remediation support services
3. interviews with key informants.

The aim of the literature review was to identify and interpret published and grey literature as well as other documentation in order to evaluate remediation support in the UK for dentistry. Using seven search databases and iterative searches, 14 articles were identified as relevant from a pool of 52 found.

The survey provided the research team with a supply-side, organisational level picture of remediation support. The survey was distributed to key supply organisations of remediation support services identified in stage one. Questions for respondents reflected the areas covered in the research questions above and included:

- the types of remedial support available;
- the geographical coverage of the support service;
- factors leading to, and the route to remediation;
- the costs associated with remediation and who meets them; and
- the impact of remediation services in terms of supporting dental professionals to keep them in the workforce.

In this review we also report on 10 key informant interviews which were undertaken. The aim of these interviews was to establish a clear, national picture of support services across the UK from a purposive sample of key informants. The research team used these interviews to clarify any issues identified in the literature or survey, as well as to fill any gaps in knowledge.

Stage three combined all quantitative and qualitative data collected, that being from the literature review, survey and interviews, to present the findings in this report. Gaps in available information were identified and considerations for future work are presented.

Main conclusions

Types of remediation support

There are multiple forms of remediation support supplied across the UK. The most common types of remediation include coaching and mentoring, careers advice, occupational health and health support, return to practice schemes and Continuing Professional Development (CPD) courses. Only

one postgraduate clinical supervision programme was identified which had a limited number of places, running on an annual basis. The majority of the remediation support identified was formal.

The types of support available to dentists and DCPs varied according to geographical location in the UK. Some areas reported having well developed support systems in place; others have very little access to support within their region. Results from this evaluation suggest that the majority of support available is targeted to dentists, but is available to DCPs. However the number of DCP's taking up support is low.

Why and how do they access support?

The majority of remediation services identified in the survey support registrants with performance concerns. The literature and interviews suggest that the health of the registrant is also becoming a more dominant area of concern, which often manifests itself through performance issues or concerns.

Self-referral and deanery-level referrals were the most common routes to remediation support services identified in this evaluation. Interviews with key individuals suggested that there is an increase in the number of dentists going through GDC Fitness to Practise procedures and seeking remediation support in advance of a hearing, in order to try to avoid restrictions on their registration. If a registrant has shown that they have made active changes to their practice, then upon attending a GDC Fitness to Practise hearing, the panel is less likely to find the registrant's fitness to practise currently impaired. Some concern was raised as to whether DCPs had access to similar advice and support.

Cost of the support

The cost data available was limited. When data on cost was provided, more contextual information was needed in order to understand what these costs did or did not cover. A comparison between different costs was therefore challenging due to incomplete information. Based upon the cost data that was supplied, it would seem that there is a large amount of variability in the costs of the provision of remediation support services across the UK.

Given salary differences, no support service reported charging dentists and DCPs different rates for services. This places a greater financial burden on lower paid dental professionals, such as dental nurses, which could discourage their access to and use of the services available.

Impact of the support

There was very little evidence identified for the routine evaluation of remediation services in terms of how well they worked in keeping registrants in the workforce and getting them back on track. In the literature two examples of good practice were identified which looked at measures of stress pre and post a remediation intervention, followed by interviews with individuals who had received support. Research in progress was also identified, concerning an evaluation of the impact of services provided by the Postgraduate Dental Teams (PgDTs) across the UK by Pearce *et al* (this is research in progress).

Survey respondents reported that they had evaluated their services but it was not clear how formal any such evaluations were. A small minority of responses could provide descriptive, quantitative data to support their answers. In the interviews, the majority of participants could provide anecdotal

support for the evaluation of their services. A reason given by interviewees for the absence of routine formal evaluation was a lack of funding.

Areas for future work

A strong remedial programme is required to support dental registrants who find themselves in difficulty. With the need to ensure fitness to practise and for the development of future continuing assurance processes, it is imperative that when a registrant is identified as unfit to practise, a high quality remedial support system is available to get them back on track.

This review has raised the following considerations to assist informing the development of continuing assurance of dental registrants' fitness to practise;

- For consideration is the establishment of a remediation providers steering group with representation from key stakeholders. The group would be responsible for overseeing and co-ordinating remediation support service activity across the UK.
- The steering group would co-ordinate the set-up of ongoing systems to monitor the provision of remediation support across the UK for dentists and DCPs to see if there is sufficient level of support in relation to the needs of all dental professionals and continuing assurance of fitness to practise.
- The remediation providers steering group could explore and seek to resolve any issues around pathways to remediation and pressures on existing providers of remediation.
- Take up of remediation by DCPs is low, compared to dentists. The steering group may wish to investigate further the reasons for this, specifically any issues with regards access to such support to ensure professional standards are reached for all groups of dental registrants as required for continuing assurance.
- The steering group could institute a formal mechanism for collecting cost information from suppliers of remediation in order to facilitate cost comparisons of different remediation services and to understand whether cost is a barrier to access for any DCPs.
- In order to ensure a good quality system of remediation support is available to help dental professionals get back on track, it is necessary to know whether existing services are effective and how they can be developed. The steering group could champion the importance of formal evaluation of remediation services to build an evidence-base of good practice and continuous quality improvement of provision.

1 Introduction

This is a report on the evaluation of remediation of dentists and Dental Care Professionals (DCPs) across the United Kingdom (UK). This research was undertaken by the University of Winchester between January and April 2015, for the General Dental Council (GDC).

1.1 Review context

1.1.1 The General Dental Council (GDC)

The GDC is the regulator of dental professionals in the United Kingdom. All dentists and DCPs (i.e. dental nurses, dental technicians, clinical dental technicians, dental hygienists, dental therapists and orthodontic therapists) must be registered with the GDC in order to work in the UK.

The GDC's statutory purpose, as set out in the Dentists Act 1984, is to protect the public by regulating the dental team. This is done by:

- registering qualified professionals
- setting standards of dental practice and conduct
- assuring the quality of dental education
- ensuring professionals keep up to date and
- helping patients with complaints.

1.1.2 Continuing Assurance

Continuing assurance of fitness to practise includes a range of policies and procedures in which dental professionals may, in the future, be required to demonstrate in order to show that they continue to be up to date and fit to practise in the context of the GDC's Standards for the Dental Team (2013). Previously termed 'revalidation' it refers to regulatory approaches that would enable the GDC to periodically ensure that those on its registers continue to be up to date and fit to practise.

In 2006, the Department of Health's review of the regulation of non-medical healthcare professions (the Foster Report) set out the characteristics of revalidation. The Department of Health published the report of the Working Group Non-medical Revalidation in 2008. This report set out 12 principles of this type of revalidation (Department of Health, 2008). In 2011, the Government published the Command Paper 'Enabling Excellence' which highlighted that a 'one size fits all' approach to non-medical revalidation would not be appropriate.

The GDC has been exploring how a scheme of revalidation may be approached within professional regulation in dentistry. A three stage model of revalidation was proposed and consulted upon in 2010. Since then, further work has explored what supporting evidence could form a basis for an approach, and this present research evaluates the extent to which professional remediation services in dentistry might currently be sufficient or otherwise to support any future scheme. The GDC now more commonly uses the term 'continuing assurance of fitness to practise' to describe its purposes in this area rather than 'revalidation'.

1.1.3 Remediation

Remediation is defined as "*supervising and monitoring the implementation of the individual practitioner's strategy to redress the aspects of underperformance identified and agreed by the detection, diagnosis and assessment processes"* (Tackling Concerns Locally, 2009, pg58).

Dental professionals may be referred to remediation services through a number of routes including by their employer or a commissioner, by the GDC (via Fitness to Practise procedures) or by a self-referral.

The Committee of Postgraduate Dental Deans and Directors (COPDEND) defines the principles of the remediation process as to:

- assure patient safety and protect the public
- return the registrant to safe practice
- have fair, consistent and transparent processes
- be appropriate
- be timely
- have clearly defined measurable outcomes
- be quality assured and
- have a transferable model for use in other groups (COPDEND, 2009).

1.1.4 Evaluation aims and research questions

The overall aim of this study was to evaluate the remediation services currently provided in the UK.

The main research questions were:

1. What types of remediation support activities exist for all forms of dental practice? (For example, the range, type, amount, and whether informal or formal).

2. Why do dentists and DCPs access such support?

3. How do dentists and DCPs access remediation?

4. What are the main costs associated with provision and participation in remediation support and who bears the costs?

5. How do remediation services positively contribute to supporting dental professionals to keep on track?

Across all of these research questions the research team also recorded:

- The level/sector at which the support was offered for dentists and DCPs, including those operating outside standard practice. For example, for primary care registrants - what was the support offered within local Clinical Commissioning Groups (CCGs), regionally at Health Education England level[1], and for private practising dental professionals?

[1] Previously referred to as deaneries. Please note in survey and interview, data respondents often referred to HEEs as deaneries.

- The geographical area where the support was offered. NCAS reported that there were "*greater geographical variations in referral rates for dentists than doctors,"* (2009, pg 43) which highlighted the need to ensure a clear geographical mapping.

- Any equality and diversity factors in relation to the remediation support provided – where possible the research team recorded any demographic data (i.e. gender, country of qualification and location). NCAS reported a change in the demographics of the dental professional population, including a higher percentage of female dentists and an increase in the number of dentists who qualified from outside of the UK (NCAS, 2009).

1.2 Methodology

This was a mixed method evaluation, combining both qualitative and quantitative data, derived from three stages of research;

- stage 1: Initial scoping
- stage 2: Data collection
- stage 3: Analysis and reporting.

The research was undertaken in accordance with the University of Winchester's policy on the ethical code of research and knowledge transfer (available on request). Participation in this project was voluntary, with opportunities for withdrawal provided at different stages of the research as part of gaining informed consent from participants. Informants were asked to complete a consent form prior to their involvement and were emailed an information sheet that explained the purpose of the research and a description of what their participation in the project meant in terms of demands of data collection and the implications of analysis and reporting. The data was stored securely and only used for the purposes of this evaluation.

1.2.1 Stage 1: Initial scoping

The aim of stage one was to define 'remediation' support services, and to establish who supplies these services for dentists and DCPs across the UK, in preparation for data collection.

1.2.1.1 Defining terminology

Dr Rachel Locke and Dr Kerry Ball collaborated with the GDC to define keywords and any exclusions or limitations for the literature search criteria (for example, timeframe and language). See Appendix i for search terms and inclusion/ exclusion criteria.

1.2.1.2 Data extraction template

A data extraction template was designed to capture the key points of information the research team identified in the literature review (stage two). For this study the data extraction form was completed in Survey Monkey. This allowed the researchers access to the same database of pooled literature summaries and provided an efficient way of summarising the key findings. The use of the data extraction form ensured comparability across all types of documents included in the review. A PDF of the data extraction form can be found in Appendix ii.

1.2.1.3 Introductory scoping calls

As part of the initial scoping stage the research team made contact with key organisations and individuals within the dental remediation network. This contact was made through telephone calls using a list of contacts provided by the GDC and snowball sampling[2] through caller suggestions. The purpose of this contact was to build knowledge about remediation support services, establish target organisations for survey distribution and key informant interviews for stage two. In total, nine scoping calls were made to organisations across the UK.

1.2.2 Stage 2: Data collection

The aim of stage two was to collect a mixture of qualitative and quantitative data using three different techniques; a literature review, a survey to suppliers of remediation support services (as identified in stage one) and semi structured interviews with key informants.

1.2.2.1 The literature review

The objective of the review was to identify and interpret published and grey literature and other documentation to evaluate remediation support in UK dentistry (see 1.1.4 for research questions). Stakeholder websites were also explored for grey literature. Search terms and the inclusion and exclusion criteria as defined in stage one of the project were used to structure the search across multiple healthcare databases (See Appendix i for inclusion and exclusion criteria).

Articles identified in the initial search stage were recorded in a review search log (see Appendix iii). Following this recording, a researcher read through each document and completed a data extraction form. As part of this form, the reviewer stated whether the document was deemed relevant or not for inclusion in the review.

The research team recorded information from the literature on where the support services are offered, and which research question was addressed in the document. Taking Pawson's approach (2006) to 'realist synthesis' within this review, the research team included *all* relevant material, such as practice and policy documents, not just academic publications.

In total seven databases were searched: EMBASE, CINAHL, HBE, HMIC, BNI, Web of Science and Google Scholar. As a result of this search, 52 articles were identified. Following review, there were 14 articles deemed relevant for inclusion in the report. Of these 14 articles, nine covered dentists alone, two covered DCPs and three covered both dentists and DCPs. Three articles were international, five covered the whole of the UK, four covered either regional or local areas in England, one covered Wales and one covered Northern Ireland.

1.2.2.2 The remediation supplier survey

The survey provided the research team with a supply-side, organisational level picture of remediation support[3]. The survey was distributed to the supply organisations of support services identified in stage one. Due to the anticipated variation in support services, it was felt that a cross section sample would not provide a representative picture of such services.

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[2] Snowball sampling is an approach to sampling where future participants are recruited to the study through existing participants.

[3] Please note that the user or dentist / DCP perspective of remediation support was not part of the research brief.

The survey was designed using Survey Monkey. This allowed the research team to distribute, track, collect and compare survey responses. Questions for respondents echoed the areas covered in the research aims and research questions (see 1.1.4). Specifically, respondents were asked about;

- the types of remedial support available (research question 1)
- the route to remediation (research question 2 and 3)
- costs associated with remediation and who meets them (research question 4)
- the impact of remediation services in terms of supporting dental professionals to keep on track (research question 5).

A PDF of the survey can be found in Appendix iv. The survey also asked about geographical coverage of the support services offered and typological factors such as geographical location and dentistry group. Multiple reminders were sent out to participants on a weekly basis in order to gain a higher response rate.

The survey was distributed to 46 remediation suppliers and 17 survey responses were returned, equating to a 37% response rate.

1.2.2.3 Key informant semi structured interviews

The aim of these interviews was to establish a clear national picture of support services across the UK from a purposive sample of key informants (see 1.1.4). The research team sought interviews with representatives from organisations which advise, provide and regulate dental remediation services. These were primarily identified through initial scoping calls and survey responses. Interviewees were asked about the perceived impact of existing types of remediation support services (research question 5), geographical coverage and the implications of equality and diversity in terms of access to remediation for both dentists and DCPs. The interviews were used to fill any gaps in knowledge identified in the literature review and survey results. They were conducted on the telephone and took between 30 and 45 minutes each to complete. Written consent was obtained from interviewees.

There were 10 interviews conducted. This included representatives from local Practitioner Advice and Support Schemes (PASS), Health Education England, a higher education institution, NCAS, health support organisations and education courses, the GDC and private providers (commercial) in England and Northern Ireland.

1.2.3 Stage 3: Analysis and reporting

1.2.3.1 Data analysis

Qualitative data from the interviews were analysed for key themes. For the quantitative data, a descriptive analysis of survey data was used to capture the key findings and comparisons. Relevant literature, survey data and interview notes were all organised and reviewed around the research questions. The researchers then summarised the results from all aspects of data collection in stage 2 to provide a comprehensive overview of the findings. A detailed breakdown of the results from each data collection stage can be found in Appendix v.

1.2.3.2 The Report

In this report, the key findings from all aspects of data collection are presented under each research objective.

- Chapter 2 presents the main types of remediation support services identified across the UK for dental professionals.
- Chapter 3 identifies the main reasons as to why and how remediation support services are accessed.
- Chapter 4 explores the main costs associated with the provision and participation in remediation support services.
- Chapter 5 presents findings which support the positive contribution of remediation support services for keeping dental professionals on track.
- Chapter 6 presents the key conclusions and discussion points for future work.

2 Types of remediation support

2.1 Literature review

The literature review identified seven articles which described a remediation service in the UK. These were:

- a survey of regional Health Education England (HEE) and Welsh and Scottish deaneries (Pearce *et al* 2015)
- the Kent area PASS (Newton *et al* 2006)
- the Dorset PASS (2014)
- the East Lancashire PASS (Whittle & Haworth 2000)
- the London Professional Support Unit (PSU) (Whiteman, Morris & Halpern 2013)
- NCAS in Northern Ireland (Morrow *et al* 2010)
- the Welsh government process for managing dentists on the performance list with performance concerns (Welsh government 2012).

2.1.1 UK wide

Pearce *et al* (2015) described the results from a survey distributed to all regional Health Education England (HEE) offices and the post graduate dental deaneries in Scotland and Wales. Ten of the 12 Postgraduate Dental Teams (PgDTs) completed the questionnaire. Key levels of support differed between each PgDT. Types of support offered included clinical and educational supervision, mentoring, appraisal and coaching. The questionnaire also reported that PgDT used additional agencies to provide support for dental registrants in difficulty including dental schools, dental practices, skills units, NCAS, community services, occupational health services and indemnity bodies. As a result support services offered across the dental teams included initial assessment, mentoring, observation, assessment of clinical skills, clinical simulation, shadowing facilities, tailored clinical or generic skills training, and supervision for return to practice schemes.

2.1.2 Regional and local schemes in England

Newton *et al* (2006) described the Kent Dental Practitioners Support Service. The service was set up to support dentists experiencing high levels of stress. It assessed problems faced by the dentists using trained counsellors and signposted the dentists to appropriate resources including financial assistance, clinical support or specific counselling for needs identified. The service was set up to be problems focused and time limited (maximum of six hours). The exact make-up of the support was tailor made to the individual, based on the initial assessment.

Whittle and Haworth (2000) described the set up of the East Lancashire PASS. This was the first PASS to be set up and was funded by the Local Dental Committee (LDC). The aim of the scheme was to offer help and support to general dental practitioners at an early stage of concern. The PASS group would receive evidence about the registrant and meet with them in person when appropriate. The scheme offered assessment processes, mentoring support and review of the process in relation to an agreed action plan.

The Dorset PASS published their annual report for 2013/2014. The scheme was launched in 2009 with the objective to "*identify practitioners who are experiencing work related issues or whose*

performance is cause for concern and to provide skilled support and guidance to help resolve these problems" (pg1, 2014). In the fifth year in which this annual report was published, one new case was identified. The type of support received included development of a Personal Development Plan (PDP), mentoring and support with audit record keeping.

Whiteman, Morris and Halpern (2013) described the set up of the London PSU. This was described as a support service which provided developmental assistance to clinicians, and dentists in the London area (Whiteman, Morris & Halpern, 2013). Support services offered within this unit included careers support, coaching and mentoring, communication skills, interactive e–learning modules, psychological support from MedNet, occupational health and return to practice schemes (Whiteman, Morris & Halpern, 2013).

2.1.3 Northern Ireland

In Northern Ireland there is a statutory obligation to involve NCAS in disciplinary cases. Despite operating in the same regulatory framework, NCAS in Northern Ireland is smaller; more self-contained and extends its remit to include social care (Morrow *et al*, 2010). The service offers advice, signposting and specialist interventions such as performance assessment, planning and back to work support (Morrow *et al,* 2010).

2.1.4 Wales

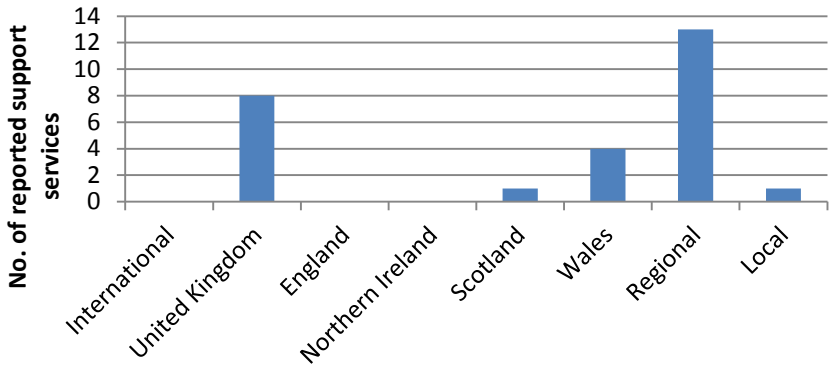
In 2012 the Welsh Government published 'Updated guidance on a model operating procedure for the management of dentists on the dental performers list whose performance is cause of concern.' The paper describes the Dental Quality and Safety Group responsible for reviewing and monitoring concerns about dentists, and identifying concerns and bringing them to the attention of the Medical Director. This Group provides advice on suitable sources of support and monitoring improvements for the dentists concerned (Welsh Government, 2012).

2.2 Survey responses

Of the 17 responses received, 12 (70.6%) stated that they did provide remediation support services and five (29.4%) did not. In these five cases it was likely that they took an advisory role rather than provided actual support.

Across these 12 providers, 27 remediation services were reported. The geographical scope of these services is shown in graph 1 below. The most frequent level of delivery of remediation support was at the regional level (for example HEE). The survey did not show any providers which had services covering the whole of either England or Northern Ireland; however there are some UK-wide services.

Figure 1 Geographical scope of survey reported support services

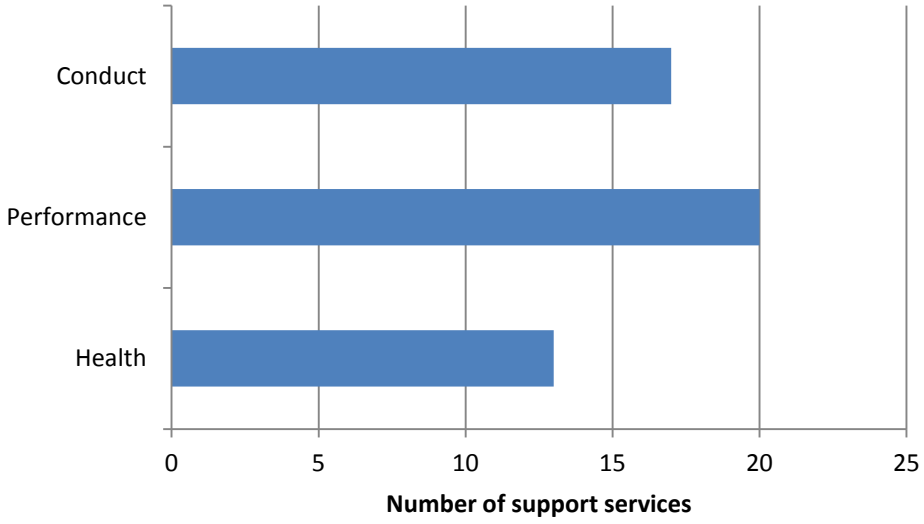


Descriptions of the services reported in the survey included re-training support, coaching and mentoring, occupational health, psychological support, the HEE system of Dental Registrants in Difficulty (DRiDs), CPD, PASS, Return to Practice scheme, career advice and clinical supervision. When asked to categorise the support each service provided, the responses showed that 66.7% (16/24) of the services reported provided coaching and mentoring, 62.5% provided communication skills, 54.2% provided career support, 50% return to practice support, 29.2% provided psychological support, 25% health support and 16.7% occupational health support.

When asked who the service was targeted at 50% (13/26) of the services reported were for dentists only and 50% (13) were for both dentists and DCPs. There were no respondents that reported remediation support services targeted to DCPs only.

The survey asked what types of concern were addressed by the support service offered. The graph below shows the number of support services offered under each type of concern. The modal (most frequent) category was support services provided to address performance concerns.

Figure 2 **Number of support services offered to address conduct, performance and health concerns.**



2.3 Interviews

2.3.1 Informal or formal support

One of the discussion points in the interviews was the understanding of what constitutes 'informal' and 'formal' remediation. The results were variable, particularly when interviewees were asked to describe informal support.

In general 'informal' was seen as support which did not require a report on progress to another body for example the GDC or an area team. Other suggestions included that anything before a PDP was created counts as informal and supervisory work in practice where tasks completed cannot be verified, and where the dentist's difficulties represent low clinical risk to patients.

There was recognition that informal remediation was harder to find, with suggestions that the local PASS's offered this type of support. They were once more wide spread but had slowly reduced in numbers. Other examples of informal support were private coaching and education programmes.

Formal remediation was seen as the support offered at HEE level or clinical supervision and would include some level of accountability or reporting on the remediation. For DCPs, there was mention of tutors as a means of support, but an acknowledgement that most support for this group of dental professionals was offered by their employer, the dentist.

2.3.2 Types of remediation support

Interviews were held with key individuals involved with providing remediation support from local PASS's, private providers of mentoring and coaching, education programmes (including clinical), deaneries, health support organisations and advisory services.

Interviews covered representatives from across the UK, including providers who supplied services regionally to UK wide. The geographical spread of the services represented by interviewees can be found in table 1 below.

Figure 3 Geographical spread of support providers represented in the interviews

Support coverage	Number of interviewees
UK wide	5
England	1
England regional (for example HEE)	3
England local (for example PASS)	1
Wales	1
Northern Ireland	1
Scotland	1

(Please note some interviewees represented more than one organisation)

The types of remediation support available are;

- carrying out initial assessments to develop a PDP
- advising and signposting to other resources such as CPD recommending the use of reflective tools and practice
- mentoring, coaching, and counselling (for health issues)
- clinical supervision. either in the dental practice or in an educational organisation
- managerial support.

These types of support are not mutually exclusive and a dental professional may access more than one type.

3 Why and how are remediation support services accessed?

3.1 Factors which may lead to performance issues (why)

3.1.1 Literature review

From the literature review, seven articles explored possible causes as to why dentists and DCPs may seek remediation support.

3.1.1.1 International

In a review of the literature, Gorter (2005) described the main factors associated with stress at work and burnout in dental hygienists. The review argued that dental hygienists, when compared to other professionals, were relatively negative about the variety of their work tasks. In a Swedish study of 495 Swedish and 254 Austrian dental hygienists, 15% reported suffering from mental exhaustion, 18% reported receiving patient complaints, 16% reported chronic headaches and 13% reported feelings of anxiety (Yalipaa *et al* 2002 cited in Gorter 2005).

3.1.1.2 UK

Patel *et al* (2011) published a review of factors which influence dental practitioner performance. The review concluded that there was an increasing number of factors that have the potential to influence dental practitioner performance; these included gender ratio (different gender work patterns and communication skills), ethnicity and skill mix of the dental workforce (effective team working reduces individual work load pressures). Other factors included professional isolation, leadership, changes to work practices, and education as possible factors in dental underperformance.

Kataria *et al* (2014) examined past performance assessments and cognitive function tests of practitioners referred to NCAS between 2008 and 2012. One hundred and nine practitioners were identified as over the age of 45, of which 14 were dentists. Since 2008 NCAS have performed neuropsychological screening on all practitioners referred for performance assessment using the Addenbrooke's Cognitive Examination Revised (ACE-R). The ACE-R has been shown to have sensitivity to the diagnosis of the dementia cut off of <88. Reasons for referral across the whole practitioner group were clinical difficulties, and governance or safety issues. Overall 22 (20.2%) practitioners were found to have ACE-R scores of <88, following assessment 14 of these 22 (63.3%) were found to have cognitive impairment. For the dentists group three (27.3% of referred dentists age 45 or over) were found to have ACE-R scores of <88.

Myers and Myers (2004) investigated the impact of stress and the health of General Dental Practitioners (GDPs) in the UK. Using a cross sectional survey, data was collected using measures of perceived stress, work stress, job satisfaction and health symptoms and behaviours. The findings showed that perceived stress was significantly related to measures of dental stress. Health behaviours such as alcohol use were associated with work stress. The article reported that a "*comparatively large number of dentists reported high levels of psychological stress symptoms*" (Myers and Myers, 2004 page 89). Newton *et al* (2006) echo Myers and Myers emphasis on stress in GDPs, reporting that high levels of work stress have been shown to be related to job dissatisfaction, physical health symptoms, poor working relationships and early retirement.

3.1.1.3 England

An article by Whittle and Haworth (2000) listed possible causes of underperformance in GDPs as professional isolation, lack of CPD, physical or mental health problems, drug and alcohol problems, stress related problems, low morale, complaints, poor practice infrastructure, workload problems, interpersonal relationship problems, tragic and upsetting professional experience and unexplained idiosyncratic behaviours.

3.1.1.4 Northern Ireland

Morrow et al (2010) reported that the majority of NCAS referrals among the 19 interviewees were in relation to clinical competence, with overlapping issues in behaviour, health and probity. Other interviewees discussed seeking NCAS advice for reassurance, expertise and objectivity (Morrow et al 2010).

3.1.2 Interviews

The main reasons for accessing remediation support identified in the interviews were: External factors to the dental practice such as patient complaints and professional isolation; and internal factors including issues around record keeping and audit, the financial challenge of running small businesses and the interpersonal dynamics within a practice. The life stage of a dental professional may also be a reason for accessing remediation support, particularly the pre-retirement stage.

Health reasons included addiction, stress and eating disorders. The general pressure of providing a service to people that do not always want to receive it and who may be anxious was also discussed in the interviews.

Reasons for DCPs accessing remediation support were acknowledged as similar to those of dentists. However the majority of interviewees added the caveat that in the majority of cases referrals from DCPs was not something that they came across often enough to be able to provide an evidenced answer.

3.2 How are remediation support services accessed

3.2.1 Survey

The majority of referrals were received from either the registrant themselves or the regional HEE and Scottish and Welsh deaneries. Overall support services reported low numbers of referrals, with all responses reporting 0-4 referrals across all routes.

3.2.2 Interviews

Local schemes (for example, PASS normally funded by the LDC) were often accessed by either self-referral or a worried colleague. Private (commercial) schemes tended to receive referrals from legal advisors, dental organisations or in-house quality assurance visits. Other referrals to remediation support was through deaneries (HEEs), defence unions, area teams, the GDC, general practitioners or family members, where there were health concerns.

One interviewee did raise a concern that Dental Technicians find it hard to access support specific to their needs and Dental Nurses struggled to fund support because of lower salaries. This was not an issue raised by other interviewees but some did comment that they thought asking about the difference between dentists and DCPs was a good question.

4 Cost information about remediation support services

4.1 Literature

Pearce *et al* (2015) reported all but a proportion of the remediation services offered were funded by the PgDT and the remainder by dentists.

4.2 Survey

Of 27 services reported, 11 were funded by the registrant themselves; six by the area team, 13 by the deanery and nine by others including indemnity providers, LDCs, and CCGs. Cost data was not available in 50% of responses. When provided, the estimated individual costs of the support service ranged from £125 per hour to £9,000 for three months. Where the survey respondent indicated that the service was funded by the registrant, costs again ranged from £125 per hour to £9000. The table below provides the type of service provided within categorised costs.

Figure 4 Categorised cost breakdown and support service description

Cost	Number of support services	Description of service
£0-257	4	Registrant funded coaching and mentoring, careers support, health support (sometimes funded by CCG's), communication skills,
£258-800	3	HEE (deanery) funded support – career support and communication skills
£801-2000	2	HEE (deanery) funded support, normally coaching and mentoring, Indemnity organisation funded support through deanery, area teams
£2000-9000	2	Registrant funded (sometimes deanery, area team part funded) postgraduate clinical supervision programme
Information not available	12	Regional and local support. Corporate bodies.

4.3 Interviews

4.3.1 NHS

The main costs associated with the provision of remediation support were; cost of clinical supervisors, training of mentors (where provided), initial screening and assessment. Any additional costs were normally charged to the registrant who participated in the remediation support. In the NHS this normally centred on the guild rate for three and a half hours plus expenses. Local schemes tended to offer free support services which were funded by the LDC.

4.3.2 Private

Cost of private (commercial) provision of support services varied considerably. Examples are listed below:

- private coaching costs around £125 an hour and typically takes six hours initially (private stress reduction support service)
- postgraduate clinical supervision programme is more costly and equates to postgraduate clinical student education fees at £9000 for a three month course
- clinical or managerial one to one support in the dental practice from clinical advisors costs the dentist £300 a month where the dentist is deemed to present a risk to patient safety
- bespoke mentoring support is usually paid for by the dentist but can also be co-funded through a raised administration fee.

5 Evaluation or impact of remediation support services

5.1 Literature

Two articles were found which had evaluated the remediation support service described. A further two international articles were identified which although they did not directly evaluate a remediation service did provide some useful information which could contribute to this evaluation.

Morrow *et al* (2010) assessed the impact of NCAS in Northern Ireland. In total, 19 referrers were interviewed. All respondents expressed satisfaction with the service and found NCAS to be approachable, accessible and neutral. The majority of referrers had worked with a local advisor. Advice was generally considered useful in terms of clarification of issues, assistance with decision making and in setting out actions to be taken. There were some perceived concerns about the NCAS reports such as delays and conflict between evidence from referrers and practitioners.

Newton *et al* (2006) evaluated the Kent area Dental Practitioner Support Service (DPSS), a local PASS, in a prospective cohort study of 20 GDPs. Assessments of stress were made by measuring experience of stress, psychological distress and ways of coping with stress before and six months after the intervention. Overall 16 practitioners completed the intervention, of which nine completed the follow up measures. In general all measures showed a reduction between the before and after measures of stress, although the sample size was small. The authors argue that in order for a stress reduction intervention to be effective, it should be tailored to the individual needs of the practitioner, within a structured intervention framework.

Bagramian *et al* (2011) reported on a six year mentoring programme for dental faculty members in the United States. The programme asked faculty members to complete a survey in 2002 and 2008. Comparison of the results showed that perceptions of support from colleagues significantly increased over time. Differences in impact of mentoring were identified between junior and senior faculty members suggesting that mentoring interventions needed to be targeted to particular age groups in order to achieve maximum impact.

Asadorrian *et al* (2006) compared two distinct types of quality assurance and quality improvement programmes for dental hygienists in Canada and assessed the impact of these programmes on practice behaviour change. The two programmes were a traditional mandatory continuing education programme and a unique portfolio based scheme. The results found no statistical differences between total activity, change opportunities or change implementation between the two programmes. However participants on the portfolio based scheme took part in more activities that yielded change opportunities and more activities that yielded appropriate change implementation, than the participants on the traditional continuing education program. The authors concluded that participants on the portfolio based scheme participated in more learning activities which were relevant to their practise and learning needs, allowing a greater efficiency in professional learning.

5.2 Survey

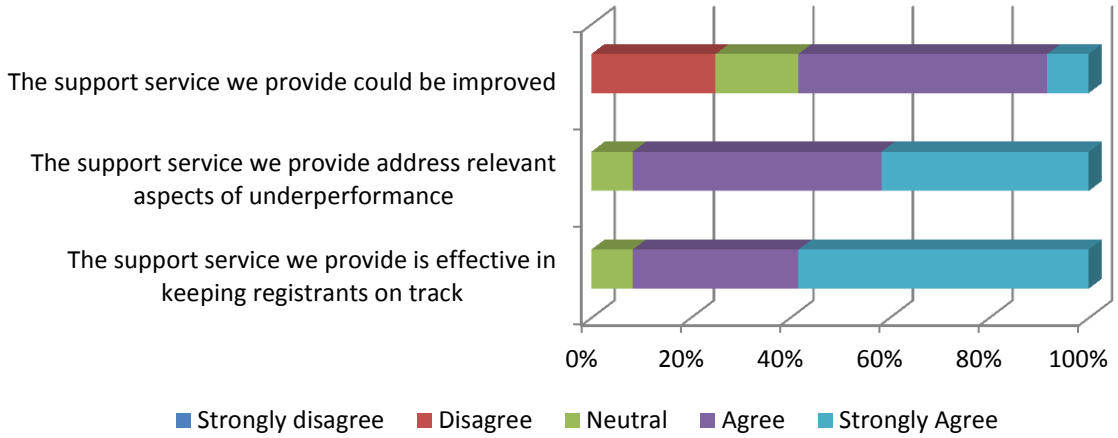
When asked if they had evaluated the support service offered, 69.6% (16/23) said' yes' they had and 30.4% (7) had not. Reporting about evaluation was fairly limited with some saying they were in the process of evaluating, others reporting registrant satisfaction, a positive effect on progression and

retention and high rates of return to practice as outcomes. Some respondents reported that formal evaluation was planned.

In order to gain some comparative information, respondents were asked how strongly they agreed or disagreed with a series of statements about the support service they offered, as well as their opinion on the general state of remediation support locally and more widely.

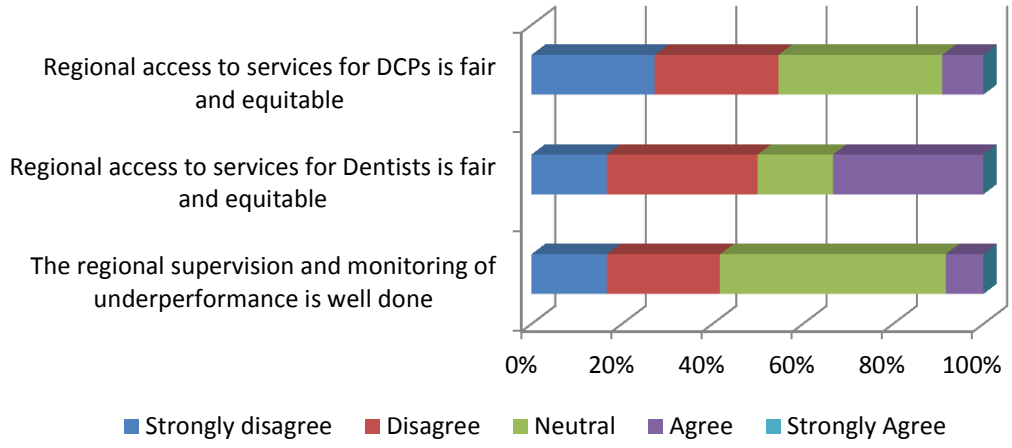
58.3% (7/12) of respondents agreed that the support service they provided could be improved. In spite of this, perception of the support service supplied was positive. 91.7% (11/12) either agreed or strongly agreed that the support service they offered provided addressed the relevant aspects of underperformance. 91.7% (11/12) respondents either agreed or strongly agreed that the support service they provided was effective in keeping registrants on track (see figure 5).

Figure 5 Level of agreement to support service offered



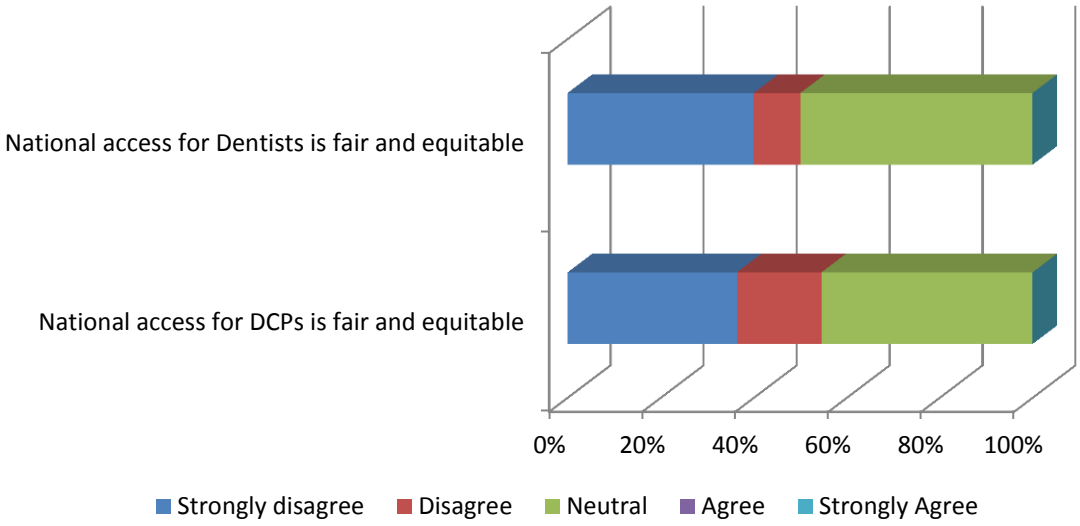
Respondents were then asked their opinion on the access and quality of regional remediation support services. Perceptions of regional support services were more variable. 54.5% (6/11) of respondents either disagreed or strongly disagreed that regional access for DCPs was fair and equitable, 36.4% were neutral(4/11). 50% (6/12) of respondents either disagreed or strongly disagreed that regional access for dentists is fair and equitable, 33.3% (4/12) agreed. 41.7% (5/12) of respondents either disagreed or strongly disagreed that the regional supervision and monitoring of underperformance is well done. 50% (6/12) were neutral (see figure 6).

Figure 6 Opinions about regional support services



Lastly respondents were asked for their opinion on access for dentists and DCPs to national support services. Perceptions around access to national support was variable, with either disagreement that access was fair or equitable or a neutral opinion being maintained. 50% (5/10) of respondents either disagreed or strongly disagreed that national access for dentists was fair and equitable, 50% (5/10) remained neutral. 54.5% (6/11) of respondents either disagreed or strongly disagreed that national access for DCPs was fair and equitable, 45.5% (5/11) remained neutral (see figure 10).

Figure 7 Opinions towards access to national support services



5.3 Interviews

Echoing the findings from the survey and literature review, the interview data suggested that the majority of evidence available to support the positive contribution of remediation for keeping dentists on track is largely anecdotal or held within organisations.

Several interviewees mentioned that plans were in place to formally evaluate services but that funds were too limited to allow this activity at the present time.

6 Conclusions

6.1 Types of remediation support

6.1.1 Discussion

Overall we identified a small number of remediation service providers. The most common types of remediation support include coaching and mentoring, careers advice, occupational health and health support, return to practice schemes and CPD courses. Only one postgraduate clinical supervision programme was identified, which had limited places, running on an annual basis.

The findings from all stages of data collection suggest that the majority of remediation services are accessed predominantly by dentists, although they can accommodate DCPs. However, uptake of support for DCPs is low. No remediation support was identified in the UK which was directly targeted at DCPs. While this was not seen as a concern by many, one interviewee raised the issue of a lack of specific support for dental technicians. The needs of this group are different from other DCPs as they are based away from the clinical area. A consequence of a lack of targeted support for specific professional groups might be an increase in the challenges around each group reaching their professional standards as required for continuing assurance.

We identified a variable approach to remediation support services across the UK in terms of the amount, the type and the level of support available. UK wide models offer formal, reactive support for dental registrants in difficulty. This model is currently being reviewed with the aim of standardising the system using 'rules of good practice.' Regional and local schemes in England offer more informal proactive support, with local schemes often seeking to target underperformance before it becomes a formal issue. As such, they have no reporting structure to feed into beyond the scheme itself. It should be noted, however that the number of these local schemes is reducing due to lack of funding.

The majority of remediation support in Scotland has been provided by NHS Education Scotland, through the Training Revision Assessment Mentoring and Support (TRAMS) programme. This programme includes coaching and mentoring and support provided by dental practitioners. Some assistance can be offered locally by Dental Practice Advisors.

Current support in Northern Ireland was found to be fairly limited. Formal deanery support has been withdrawn due to lack of regulation and limited funds. More informal support around stress is being offered through a coaching and educational programme. NCAS also provides a level of support within Northern Ireland such as signposting, assessment, planning and some interventions.

In Wales local support is offered through Dental Practice Advisors. These advisors are experienced dentists who are employed by local health boards to support and mentor dentists in difficulty. More formal support is offered through the Welsh Assembly Government with the Dental Quality and Safety Group (currently under review) which advises on suitable sources of support for dentists about whom concerns have been raised.

6.1.2 Consideration for future work

A strong remedial programme is required to support dental registrants who find themselves in difficulty. With the need to ensure fitness to practise and for the development of continuing assurance processes, it is imperative that when a registrant is identified as not fit to practise, a high quality remedial support system is available to get them back on track.

For consideration we propose the set up of a central providers steering group. This group would be UK wide with representation from all four countries as well as local, national, commercial and NHS providers. In addition to this we would propose representation in the group from key stakeholders such as the GDC, professional groups, indemnity providers and NCAS. The group would be responsible for overseeing and co-ordinating remediation activity across the UK and would be able to lead on taking forward any co-ordinated remediation programme.

The steering group would co-ordinate the set-up of ongoing systems to monitor the provision of remediation across the UK for dentists and DCPs to see if there is sufficient level of support in relation to the needs of all dental professionals and continuing assurance of fitness to practise. This monitoring would include the type of support being offered, and the amount and the level of support being provided geographically. In this way gaps in provision could be highlighted and addressed.

6.2 Why and how are remediation support services being accessed?

6.2.1 Discussion

Results from the literature and interviews identified an emphasis on health as a common factor for underperformance. A major theme in the literature is stress and the risk of burnout amongst dentists; this theme was echoed in the interviews. Other health issues discussed included addiction problems and mental health concerns. Work factors such as dentists being located in isolated practices and challenges around running small businesses were also raised.

The most common routes to remediation are self-referral and referral into structures that are HEE (deanery) led. It is important to note here that even when the GDC requires action following a practice committee hearing, it is still up to the registrant to seek remedial support. A theme of the interview discussions was the need to formalise the pathways to remediation particularly when a registrant has conditions following a fitness to practise case, in order to enable access to all information at as early a stage as possible. It was noted that in some instances where the responsibility is left to the registrant to seek support, they often do so at a late stage in the process, often near action deadlines, which places pressure on deaneries.

The interviews also identified a perceived increase in the number of registrants seeking remediation support prior to GDC procedures in order to avoid or reduce potential actions or limitations to practice at a later stage. If a registrant has shown that they have made active changes to their practice, then upon attending a GDC Fitness to Practise hearing, the panel is less likely to find the registrant's fitness to practise currently impaired. One of the interviewees questioned whether DCPs would have the same access to advice and representation which might preclude them from taking similar preventative steps.

6.2.2 Consideration for future work

The providers steering group could explore and seek to resolve the issue around pathways to remediation and existing pressures on providers.

This evaluation has highlighted that take up of remediation by DCPs is low, compared to dentists. The steering group could investigate further the reasons for this, specifically as to any issues with regards access to such support to ensure professional standards can be reached for all groups of dental registrants.

6.3 Cost information

6.3.1 Discussion

The cost data available was found to be limited. Where cost data was provided, more contextual information was needed in order to precisely understand what these costs covered. A comparison of costs across different support services was therefore challenging and inappropriate. In the cost data that was supplied, there was found to be a large variability in the costs of the provision of remediation support across the UK. Most support is either funded by the HEE (deanery) or the dental professional themselves. However this tends to be within or at the agreed guild rate,[4] which serves to limit cost for the registrant. Local schemes tended to be free to the registrant, although there does appear to be a decline in number of these schemes available across the UK. A consequence of a reduction in this local level of support, where its key objective is early intervention may be an increase in the demand for more formal, longer and serious forms of support at a later stage.

Health support was often found to be funded by CCGs in England or by a charity. Private provider support costs varied as some provided it as part of the corporate package, and others charged an hourly rate. The highest cost identified was a postgraduate clinical supervision programme which was a formal academic programme of education and support.

In spite of salary differences, no support service reported charging dentists and DCPs different rates. This places a greater financial burden on lower paid registrants, such as dental nurses, which could act to discourage or prohibit their use of the services available.

6.3.2 Consideration for future work

The steering group could be asked to institute a formal mechanism for collecting cost information from suppliers of remediation in order to facilitate cost comparisons of different remediation services and to understand whether cost acts as a barrier currently to DCPs accessing help.

6.4 Evaluation and impact

6.4.1 Discussion

There was very little evidence identified which was derived from formal service evaluations, for instance in terms of how well these remediation support services were working in keeping registrants in the workforce. As a result of this it is unclear whether current remediation is effective. Two examples of good practice were identified in the literature; these looked at measures of stress

[4] Benchmark rate for payment of a dentist's time taken out of surgery

pre and post intervention, followed by interviews with individuals who had received support. It was also identified that there will be an exploration of the impact of services provided by the PgDTs across the UK as part of Pearce *et al*'s research (to be published).

Survey respondents stated that they had evaluated their service(s) but it was not clear from their responses how formal their evaluation was. A small minority of responses provided descriptive, quantitative data to support their answers. As echoed in the interviews, the majority of interviewees could provide anecdotal evidence in support of success or quality of the service. The most common reason given by interviewees for the lack of formal evaluation was a lack of funding

When asked to evaluate their service through rated opinion statements, survey respondents showed positive views towards provision (91.7% agreeing or strongly agreeing that their service addressed relevant aspects of underperformance and was effective in keeping registrants on track). There was also recognition that their service could be improved in 58.3% of cases.

Opinion about regional and national access to remediation support was less positive than the views expressed about their own services for both dentists and DCPs. However there was no evidence provided by the majority of respondents that access to remediation services was any different for dentists and DCPs, despite several providers stating that they received very few, if any, referrals from DCPs. In the interviews, where this issue was explored further, dentists were thought to be more likely to seek remedial support because of their professional autonomy and responsibility, whereas DCPs, being employees, were more likely to seek support from their employer, the dentist. It is not clear whether the proportionally lower numbers of DCPs accessing the reported support services is due to issues around inequalities in access to the services or due to concerns being dealt with elsewhere.

6.4.2 Consideration for future work

Good quality support services will outweigh quantity of support services. In order to ensure a good quality system is available to support dental professionals who find themselves in difficulty, it would be beneficial to know whether existing services are effective and how if at all they need to be developed. The steering group could promote the importance of formal evaluation of remediation services to ensure continuous quality service improvement and to build an evidence-base of good practice for sharing more widely with existing and future providers of remediation.

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