Annual Survey of Registrants 2013

Research Report for

The General Dental Council

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Enventure Research
Titan Business Centre, Central Arcade, Cleckheaton, West Yorkshire BD19 5DN
T: 01274 866845 F: 01274 877555 W: www.enventure.co.uk

Report prepared by:

Matthew Thurman
matthewthurman@enventure.co.uk

Report reviewed by:

Kayleigh Haigh
kayleighhaigh@enventure.co.uk

Enventure Research

Head Office:
Titan Business Centre, Central Arcade, Cleckheaton
West Yorkshire BD19 5DN
T: 01274 866845 F: 01274 877555

London Office:
Smithfield Business Centre, 5 St John's Lane, London, EC1M 4BH
T: 0207 549 1616

W: www.enventure.co.uk E: info@enventure.co.uk

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Executive Summary

Aims and objectives

Enventure Research, an independent research agency, was commissioned by the General Dental Council (GDC) to undertake its Annual Survey of Registrants, which it carries out as part of its commitment to using a research base to inform policy and practice. There were two elements to the Annual Survey of Registrants; a large-scale online survey followed by an extensive programme of qualitative research to investigate key themes highlighted in the survey results.

The aim of the Annual Survey of Registrants is to provide valid and statistically reliable data and qualitative evidence of GDC registrants' views on key aspects of its work to help inform future GDC policy and performance. Specific objectives within this aim are to:

- Provide benchmarking of data and track views, attitudes and perceived GDC performance levels
- Obtain registrant insight into key policy initiatives
- Test registrants' views and understanding of current topics and issues within dental regulation and the dental profession
- 'Horizon scan' and identify emerging policy issues with registrants
- Explore any key themes or issues emerging from the survey results in greater depth

Methodology

A mixed quantitative and qualitative approach was taken to this research in the form of an online survey (quantitative research), focus groups and in depth telephone interviews (qualitative research). Qualitative research was included alongside the quantitative survey to allow a more exploratory approach, providing a greater depth of understanding on certain topics within the survey and increased insight into underlying attitudes and opinions, which it is not possible to achieve via a survey. A full explanation of the differences between, and purposes of, the two types of research can be found in Paragraph 1.3.1 of the report.

The online survey was issued to a stratified random sample of 22,004 GDC registrants, drawn from the GDC registrant database, in order to ensure that a representative response to the survey was achieved, based on gender, age, profession, number of years registered and country.

During a six week period, 3,611 registrants completed the survey (a response rate of 16.4%), providing a very robust sample size for analysis. The reliability of survey results depends on the base size for each question (the number of respondents who answered each question). As some questions were only asked to certain proportions of respondents, base sizes may vary. The smaller the base size, the less reliable the result tends to be, as the margin of error increases. A full explanation of the statistical reliability of the survey results can be found in Paragraph 1.6 of the report.

A discussion guide was designed to form the basis of discussion during the focus groups and in depth interviews. The guide was based around the results of the online survey to stimulate discussion and provide greater understanding of the results, and also explored other standalone areas for discussion. Five focus groups and 24 in depth interviews took place, all moderated by researchers from Enventure Research. Participants were stratified to be as representative of the GDC as possible in terms of dental professional group, gender, age, number of years registered and country of qualification. In total, 70 GDC registrants took part in the qualitative research.

Enventure has also supplied the GDC with a full set of data tables related to the survey which will be published on the GDC website.

Registrants who took part in the online survey are referred to as 'respondents' and registrants who took part in the qualitative research are referred to as 'participants'.

Key Findings

The Annual Survey of Registrants was split into two main areas: 1) baseline questions and discussion topics which have been repeated on an annual or biennial basis to track registrant attitudes and opinions over time and 2) strategic or topical policy issue questions and discussion topics which are unique to this year's survey.

Where notable, variations in views between DCPs groups and dentists have been described. Significant sub-group analysis of the perspectives from the individual DCP registrant groups and in relation to demographics can be found throughout the main body of the report.

Annual/biennial survey findings

The future of dentistry
Results from the online survey found that a slightly larger proportion of respondents were optimistic rather than pessimistic about the future of the dental profession over the next two years. Most DCP groups tended to be more optimistic when compared to dentists and dental technicians who were more likely to indicate that they were pessimistic.

The most common area of optimism suggested was learning and development, as seen in 2012, which was suggested by a significantly larger proportion of dental nurses. The most common areas of pessimism suggested were changes in regulation, financial issues and the new NHS dental contract, all of which were suggested by a greater proportion of dentists. These three areas of pessimism were each suggested by a smaller percentage of respondents when compared to the results from 2012.

Challenges
The greatest challenges in current daily practice were identified in the survey results as keeping up to date with changes in guidance, rules and the law, and finding time to and opportunities to develop. The proportion of respondents suggesting meeting the demands of regulation as a challenge fell slightly between the 2013 and 2012 results.

The overall level of regulation
Opinion was almost equally split in the survey results between those who felt that the overall regulation of dentistry was too much and those who felt it was about right, with a slight increase in the proportion who felt it was about right from 2012 to 2013. The sample shows that a larger proportion of dentists indicated that regulation was too much and more DCPs that it was about right. As seen in 2012, as the number of years registered increased, registrants were more likely to feel that the level of regulation was too much.

In the qualitative research, those who felt that the current level of regulation was too high generally focused on what was perceived to be excessive paperwork and procedures which made it difficult to carry out day-to-day activities, leading to some dental professionals feeling patronised or as though they were trying to be caught out. However, it was also widely accepted that despite regulation being difficult at times, it was absolutely necessary to ensure patient safety and high levels of care. Research

participants who felt that the level of regulation was about right tended to state that current regulations did not impede them in their daily practice and that, whilst they could understand why some registrants may find regulation frustrating at times, it was essential to ensure best practice.

Some confusion was expressed by qualitative research participants as to who was responsible for regulation when there were organisations other than the GDC in operation such as the Care Quality Commission (CQC) and bodies in other nations of the UK, which some felt led to a lack of clarity.

Awareness of and confidence in the GDC

Almost all online survey respondents knew that the GDC were responsible for regulating dentistry (96%). Other suggested organisations included the CQC, the PCT/local health boards and the Department of Health. The survey found that the majority of respondents said that they knew a fair amount about the GDC (61%), yet a significant proportion said that they did not know very much (34%). Only a small proportion indicated that they knew a great deal about the GDC (5%).

When asked about how confident they were in the GDC's ability to regulate dentists and DCPs effectively, the majority of survey respondents said that they were in some way confident (67%). The majority of survey respondents also indicated that they were in some way confident that both dentists and DCPs were following the GDC guidance (82% and 80% respectively).

The reputation of the GDC

The largest proportion of survey respondents indicated that they would be neutral about the GDC, with only small proportions stating that they would speak highly or critically of the GDC. This result was also seen in 2011 and 2012.

In response to a series of statements about the GDC, 'the GDC protects the patient' received the highest level of agreement, followed by 'the GDC has a clear regulatory role' and 'the GDC ensures that proper standards are maintained in the practice of dentistry'. When comparing survey results to those collected in 2011, for each statement the proportion of respondents who strongly agree has decreased and the proportion who either agree or neither agree nor disagree has increased.

Qualitative research participants provided more in depth feedback in relation to some of the statements about the GDC. In relation to the statement 'the GDC acts in a fair and proportionate way', opinions were split between those who felt that the GDC were fair in their rulings based on what they had read in the GDC gazette or heard from colleagues, and those who felt that the GDC was sometimes 'heavy handed' and disproportionate in the way that it regulated. It was also suggested that Fitness to Practise panels could be seen as unfair due to the inclusion of lay people with insufficient knowledge of dentistry.

Qualitative research participants also generally disagreed with the statement 'the GDC is efficient', citing high Annual Registration Fees, the cost of Fitness to Practise procedures and a central London location as their reasons. However, it was also suggested that it was difficult to judge whether the GDC was efficient or not due to a lack of knowledge.

The statement 'the GDC protects the patient' generated much discussion amongst qualitative research participants. Whilst they all agreed that this was true, it was widely felt that the GDC did little to support dental professionals and that they perceived that they would always take the side of the patient over the dental professional if a concern was raised.

Survey respondents felt that the GDC was more in touch with the views of dentists and patients than it was with the views of DCPs. However, the results show an increase in

the proportion of respondents stating that they thought the GDC was in touch with each of these groups when compared to the 2011 and 2012 survey results.

The Annual Retention Fee and cost-effectiveness
Most survey respondents thought that the Annual Retention Fee for dentists and DCPs was too high. 44% of all survey respondents thought that the dentist fee was too high and 60% thought that the DCP fee was too high. However, both figures represent a small decrease from the results of the 2012 survey.

Feedback from the qualitative research found that that most registrants felt the level of fee for dental nurses was too high. Participants from all dental professional groups agreed with this view, explaining that it was unfair to expect dental nurses to pay the same as dental therapists and hygienists, despite their salary often being significantly less. A significant number of other DCPs and dentists also found their own fee level to be high, which they based on awareness of what other professions paid to be regulated.

As seen in the 2012 qualitative research, the most common suggestions for changes to the Annual Retention Fee were based around the registrant group, their potential income, the number of hours they work, and their level of risk to patients.

Just under half of survey respondents felt that the GDC was not cost-effective, but this represents a slight decrease when compared to the results from the 2012 online survey.

Communication from the GDC
The majority of survey respondents felt that the GDC communicated with them effectively (71%), almost the same proportion as in 2012. A larger proportion of dental hygienists felt that the GDC was effective in its communication with them, which was not the case for dental technicians.

The most common method of finding out information about the GDC was via the GDC website, followed by the GDC Gazette by post and the GDC Gazette online. When compared to the results collected in 2012, this shows an increase in use of the website, Gazette online and e-newsletter and a decrease in use of the Gazette by post.

Topical policy issue findings

Written CPD plans
The majority of online survey respondents said that they did not have a written plan of the CPD that they intended to carry out in the next year (60%). Written CPD plans were explored in the qualitative research, which found that participants generally did not like the idea as they felt that they would be difficult to create and follow, and that the benefits to having a written plan were not that immediate for most dental professionals. However, it was felt that in some cases a written plan could have some benefit, for example with those who had recently qualified.

Direct Access
The online survey found that a third of DCPs indicated that they would take up the option to provide services directly to patients, whereas a slightly larger proportion said that they would continue to operate under a dentist's prescription. This represents a decrease in the proportion of respondents who said that they would take up the option between the 2012 and 2013 findings. Of these respondents, the majority said that they would plan to practise where they were and not move to another practice or open up their own practice (64%), and just over half said that they would take up the option within a year of it becoming available.

DCP qualitative research participants indicated that they could see the benefits of Direct Access and felt that it was the right way forward for dentistry. However, it was felt that there were currently several barriers to taking up the option for DCPs, including what they perceived to be vague and specific wording in the GDC guidance, a lack of confidence amongst some DCPs, a lack of training available to increase the skills of DCPs and low levels of awareness of the ability of DCPs to provide services directly amongst the public.

Raising a concern

The majority of survey respondents said that they would know where to go to raise a concern about poor standards (88%), and just under half said that they had come across an issue that they felt should have been raised as a concern at least once. Over a third of respondents indicated that they had raised a concern about the practice or behaviour of a dental professional to someone in their place of work, but almost all said that they had not raised a concern like this to the GDC. Those who had come across an issue that they felt should be raised as a concern were far more likely to go to someone in their place of work rather than to the GDC.

The majority of survey respondents agreed that their place of work was one where staff can raise concerns openly (80%), concerns are taken seriously (78%), concerns are investigated effectively (72%) and raising a concern would not be held against them (66%). However, those who had previously raised a concern were slightly more likely to disagree with these statements about their workplace. The majority of respondents also stated that dental professionals who fail to report concerns should be investigated at their workplace in the first instance rather than being referred straight to the GDC (84%).

Qualitative research feedback highlighted that raising concerns could be difficult in dentistry, with concerns about job security cited as a reason why. All participants said that they would prefer to deal with a concern in their workplace and that they would only take a concern to the GDC as a last resort or if the concern was major (such as serious patient neglect or criminal activity).

Survey results show that most respondents were either very or fairly confident that appropriate action would be taken by a regulator should patients receive poor care in a variety of scenarios (a total of 78% on average). Comparing these results to those found for this question in the Patient and Public survey highlights that GDC registrants were far more confident that appropriate action would be taken than patients and the public (a total of 50% on average).

Over half of survey respondents who had registered with the GDC in the last five years said that, before registration, their education course had covered how to raise concerns about poor standards of care (57%), yet a significant minority stated that it had not (43%). The majority of all respondents said that raising a concern about poor standards of care had featured in their training since registration (61%), but again a significant and surprising minority stated that it had not (39%). However, most survey respondents stated that they felt confident about raising a concern as a result of their education or training (84%).

Providing an explanation when something goes wrong

The majority of survey respondents thought that it was likely that a dental professional would provide an explanation to a patient when something has gone wrong with their care or treatment (87%). This question was also asked in the GDC's Patient and Public Survey 2013, where a smaller proportion of respondents indicated that an explanation would be likely (69%).

Checking disciplinary records
Only a small proportion of online survey respondents indicated that they had ever checked whether dental professionals they have worked with have ever had any disciplinary actions taken against them (21%). Of those who had, the most common method of checking was by consulting the GDC, whereas those who had had not were less sure, with some indicating that they did not know how they would check and others stating that they would ask staff at their workplace.

Using feedback to enhance quality and patient choice
At the time of designing the survey, the government was discussing plans to introduce a star rating system for hospitals and doctors. Over half of online survey respondents indicated that a star rating system would be useful in helping patients choose a dentist and in improving the quality of dentistry.

Qualitative research participants provided further detail about using feedback to enhance quality and patient choice. Most participants already collected patient feedback in some way, but it was generally felt that patient feedback was often a problematic area due to differing perceptions of good and bad treatment and the difficulties in responding to negative feedback. It was suggested that a standard and anonymous method of obtaining feedback from dental workplaces would be effective as it would build a more honest and accurate picture of each practice.

Transition to independent practice
Dentists who had registered with the GDC in the last five years were asked to indicate how prepared they were for independent practice as a safe beginner upon qualification as part of the online survey. The majority of those who responded said that they were quite confident (56%), with a smaller proportion saying that they were very confident (16%). However, a quarter indicated that they were not very confident upon qualification.

Workplace inspections
The majority of online survey participants had undergone one or more external inspection at their place of work in the past two years (69%). The most common number of external inspections were one or two and the majority of inspections were carried out by different regulators. Four in five respondents indicated that they felt the inspections they had experienced were either quite or very effective (79%).

Feedback from the qualitative research regarding inspections found that almost all participants had undergone some kind of inspection from an organisation specific to the country in which they worked (CQC, HIW, RQIA, NHS Scotland). It was generally felt that these inspections were more focused on paperwork and box ticking rather than on clinical procedure and issues that directly affected patient safety, and that the knowledge and experience of those who conducted inspections was not specific to dentistry, meaning that the inspectors often did not know what they were looking for. However, in line with the online survey results, many participants felt that the inspections they had experienced were effective as they ensured that their workplace was always prepared for an inspection, so worked to a high level of quality, that they could highlight areas which may require updating, and that they reassure patients.

Overseas dental professionals
Half of online survey respondents thought that overseas qualified dentists and DCPs in the UK receive training about how the UK dental system works, but only a third thought that they received training about how dental patients expect to be treated in the UK.

When this topic was explored in the qualitative research, participants were either vaguely aware of some elements of training received by overseas qualified dental professionals about how the UK dental system works, or admitted that they did not know

what training they received. However, all participants felt that they should receive training on both these topics in order to bring all dental professionals working in the UK up to the same standards. It was also highlighted that it should not matter whether the professional was from within the EU or not.

Complaints
The largest proportion of online survey respondents indicated that the number of complaints they had received in their workplace had stayed the same during the last year (41%). The majority of respondents felt that their patient complaints procedure was either quite or very effective at identifying complaints that could be investigated using the workplace patient complaints process (82%), but a smaller proportion felt that their complaints procedure was either quite or very effective at referring patient complaints to other organisations to investigate (69%).

The NHS contract
Dentists who took part in the qualitative research were asked to provide their thoughts on the current NHS dental contract and also what they expected from the new NHS contract currently being piloted. The current NHS contract was almost universally viewed in a negative way, with participants focusing on the problems with the system of Units of Dental Activity (UDAs) that were detrimental to both patients in terms of the level of care they receive and dental professionals in terms of the way they are financially rewarded for carrying out NHS treatments.

The benefits of the proposed new NHS contract were perceived to be the focus on preventative dentistry which was seen as appropriate given changing patient circumstances and the move away from simply 'drilling and filling'. However, a number of concerns and drawbacks were also raised by participants, including the amount of time that would be required with each patient and the shifting of responsibility for certain aspects of patient care from dentists to other dental professional groups such as dental therapists and hygienists.

GDC strategy and priorities
A number of common themes emerged when qualitative research participants were asked to suggest what the GDC's priorities should be when preparing its new Strategy to set the direction of the Council for the coming years. These included;

- Becoming more supportive and approachable for dental professionals
- Reviewing the Annual Retention Fee, particularly for dental nurses
- Developing guidelines for employers to help create a fairer dental nurse salary
- Relocating the GDC to become more cost-efficient
- Further defining the scope of practice for each dental professional group and being more specific in defining Direct Access for DCPs

GDC standards for the dental team
The survey is gathering evidence about attitudes towards the new Standards for the Dental Team, distributed to registrants in August 2013, taking effect on 30 September.

There are two strands to the research:

A sample of online survey respondents answered three additional questions to review the GDC's draft interactive website pages for the new Standards including case studies, scenarios, FAQs and an advertising checklist. Results to these questions show that all pages were found to be useful and easy to read, and that the majority of participants said they would be likely to consult the page if they were looking for guidance on the standards. The FAQs was seen to be the page most likely to be consulted if looking for guidance on the standards.

In April 2014, six months after publication of the Standards, a bespoke survey will be sent to a stratified representative sample of registrants. The survey covers awareness, use of the standards and preferences for communication. The results of the survey will be available in April 2014 and used as evidence in the evaluation of the standards.

The views expressed in this report are those of Enventure Research and not necessarily shared by the General Dental Council.

1. The Research Programme

1.1 Introduction

The General Dental Council (GDC) is an organisation which regulates all practicing dental professionals within the United Kingdom, protecting patients and members of the public. All dental professionals, including dentists and dental care professionals (DCPs) are required to be registered with the GDC to practise. There are approximately 102,800 dental professionals registered with the GDC. Of these, 62,500 are DCPs and 40,300 are dentists.

As part of its commitment to using research to build a strong evidence base to inform the organisation's policy and practice, the GDC conducts an annual survey to consult with its registrants to provide robust quantitative data and evidence of their views on key aspects of the GDC's work. This year (2013) is the third time that the survey has been conducted.

In order to provide an in depth understanding of the survey results, the GDC also wished to undertake a programme of qualitative research with its registrants, following up on any key themes which are highlighted in the survey results. The findings from this research will be used to influence GDC business planning and performance management processes.

Enventure Research was commissioned to undertake this research. All research was conducted independently by Enventure Research to ensure a true and accurate reflection of registrants' views was achieved.

1.2 Aims and objectives

The aim of the research was to provide valid and statistically reliable quantitative data and qualitative evidence of GDC registrants' views on key aspects of its work to help inform future GDC policy and performance. Within this overall aim, the project objectives were to:

- Provide benchmarking of data to track views, attitudes and perceived performance levels
- Obtain registrants' insight into key policy initiatives
- Test registrants' views and understanding of current topics and issues within dental regulation and the dentistry profession
- 'Horizon scan' and identify emerging policy issues with registrants
- Explore more in-depth any key themes or issues emerging from the survey results

1.3 Methodology

1.3.1 Mixed methodology of quantitative and qualitative research

A mixed methodology of quantitative and qualitative approaches was undertaken for this research in the form of an online survey, focus groups and in depth interviews.

The purpose of quantitative research is to determine conclusively what any given population thinks about certain issues by collating the views of a sample from within that population, in this case, a representative sample of dental professionals registered with the GDC. By analysing the results of a quantitative survey we can make accurate assumptions and conclusions based on what the overall population of dental professionals thinks, subject to certain margins of error. In order to reduce the margin of error, a large sample size is required.

Qualitative research differs from quantitative research in that it is not meant to be statistically representative or to produce any definitive conclusions. It is used instead to explore opinions, attitudes and motivations in greater depth, exploring the reasons that sit behind the views that may be expressed within a survey. Qualitative research is ideal for exploring issues which are highlighted in quantitative survey results in depth, asking more probing questions, something which is not possible in a quantitative setting. Qualitative research is undertaken in the form of open-ended and free-flowing discussion and deliberation based around a number of broad themes, topics or issues. The number of participants involved in qualitative research is generally much smaller than those involved in quantitative research, as much more time is spent with each participant to gain a greater depth of understanding.

The quantitative research (the online survey) allowed for robust statistical data to be collected from a large, representative number of GDC registrants. The qualitative research (focus groups and in depth interview discussions carried out with a select number of GDC registrants) provided in depth exploration of issues and key themes that were highlighted in the results of the online survey.

1.3.2 Questionnaire design

A questionnaire was designed by the GDC and Enventure Research. It consisted of 68 questions which covered the following topic areas:

- The future of dentistry
- Challenges in every day practice
- Perspectives on the GDC
- The Annual Retention Fee
- Communication
- Appraisals and audits
- Direct access
- Raising concerns
- Checking disciplinary records
- Star ratings
- Transition to independent practice
- Workplace inspections
- Cultural adaptation
- Complaints

For reference, a copy of the questionnaire can be found in **Appendix B**.

1.3.3 Sampling

It was essential to ensure a representative sample of registrants took part in the GDC's Annual Survey of Registrants to allow for confidence, robustness and accuracy in any results drawn.

The GDC registrant database, which details all practising dental professionals registered with the GDC, was used as the sample frame, from which a random sample of registrants was drawn. To ensure the sample drawn was representative, the registrant database was first stratified by gender, age, profession, number of years registered and country. A stratified random sample of 22,004 registrants was drawn, which included a booster sample of 4,702 DCP registrants who were added to increase the response rate from these professional groups.

1.3.4 Online survey fieldwork

The survey was hosted online by Enventure Research between 19 November and 31 December 2013. All GDC registrants within the sample received a personalised email invitation which contained a unique link to take part in the survey. During the fieldwork period, those who were yet to complete the survey were targeted with reminder email invitations. Three reminder emails were issued to encourage registrants to participate in the survey. Respondents were able to save their progress and return to the questionnaire at a later date if they wished.

During the six week period, 3,611 GDC registrants took part in the survey which provides a very robust sample size to draw results from. Taking into account the number of invalid email addresses, this equates to a response rate of 16.4%. **Table 1** below provides a demographic breakdown of respondents.

Table 1 – Demographic profile of respondents

Demographic	Total	Dentists	DCP
Male	27%	53%	10%
Female	73%	47%	89%
Refused	0%	0%	0%
16-21	1%	-	2%
22-30	27%	28%	26%
31-40	29%	28%	30%
41-50	23%	21%	24%
51-60	16%	16%	16%
61-65	3%	5%	2%
66+	1%	2%	1%
Refused	0%	0%	0%
White	82%	71%	89%
Asian or Asian British	9%	17%	4%
Black or Black British	2%	2%	3%
Mixed	1%	1%	1%
Chinese or other ethnic group	1%	2%	0%
Refused	4%	6%	3%

1.3.5 Discussion guide design

Focus groups and in depth interviews were facilitated by researchers from Enventure Research, who followed a specifically designed discussion guide to allow all relevant topics to be covered. The discussion guide was designed to highlight key results from the online survey to participants in order to stimulate discussion and explore the reasons behind the results in greater depth. Other standalone topics were also explored during discussions. The main areas covered within the discussion guide were:

- Attitudes towards the regulation of dentistry
- The reputation of the GDC
- The Annual Retention Fee
- Continuing Professional Development plans
- Direct Access (DCPs only)
- Raising concerns
- Using feedback to enhance service quality and patient choice
- Inspections
- Overseas qualifications
- The NHS contract

The focus group and in depth interview discussion guide can be found in **Appendix C**.

1.3.6 Focus group and in depth interview stratification

A series of five focus groups and 24 in depth interviews was held with a selection of GDC registrants between 12 and 28 February 2014.

Focus groups were stratified to ensure that those who attended were broadly representative of all GDC registrants in terms of country, profession and length of time on the register, as well as representative of the UK population in terms of gender and ethnicity. Three groups were held in England (North, Midlands, South), one was held in Scotland and one in Wales. Between seven and ten dental professionals attended each group.

In depth interviews were also stratified to ensure a range of dental professional groups were included within the research working in different countries (including Northern Ireland), in a mix of urban and rural areas and with different levels of experience.

The stratification of focus groups and in depth interviews can be found in **Appendix A**.

In total, 70 GDC registrants took part in the qualitative research.

1.4 Weighting of survey sample

A stratified random sample was used to ensure a representative sample was achieved in terms of profession, number of years registered, geographical location and key demographics. Therefore, the returned sample was generally representative of the GDC registrant database. However, weights have been applied to the returned data to ensure that it is as close to the profile of registrants as possible, using the GDC registrant database supplied by the GDC to Enventure in November 2013. Weighting adjusts the proportions of certain groups within a sample to match more closely to the proportions in the target population. All results presented within this report are based on the weighted data.

1.5 Previous research and Patient and Public Survey

As this is the third Annual Survey of Registrants, it is possible to compare certain results to those collected in the 2011 and 2012 surveys. Where appropriate, these results have been highlighted for comparison to track the views and opinions of registrants over the past two years. Results from the Patient and Public Survey 2013 have also been included where relevant.

1.6 Interpretation of the quantitative data

This report contains several tables and charts that present survey results. In some instances, the responses may not add up to 100%. There are several reasons why this might happen:

- The question may have allowed each respondent to give more than one answer
- Only the most common responses may be shown in the table or chart
- Individual percentages are rounded to the nearest whole number so the total may come to 99% or 101%
- A response of between 0% and 1% will be shown as 0%.

As the online survey was undertaken with a sample of registrants, and not the entire population, all results are subject to sampling tolerances. However, as the response rate to the online survey was large (3,611 registrants of 102,800 took part in the survey), the margin of error when interpreting the results is low.

For example, when interpreting the results to a survey question which all respondents answered, where 50% of registrants in the sample responded with a particular answer, there is a 95% chance that this result would not vary by more than +/- 1.6 percentage points had the result been obtained from the entire registrant population.

Where not all survey respondents have answered a question, as not all questions were relevant to all respondents, the sample size is sometimes smaller. The smaller the sample size, the less reliable the result tends to be. For example, only 74 respondents were asked which social media channels they would prefer the GDC to use (Q26). Here, the sampling tolerance would be +/- 11.4 percentage points.[1]

Subgroup analysis has been undertaken to explore the results provided by different registrant groups and other key subgroups such as the number of years registered. This analysis has only been carried out where the sample size is seen to be sufficient for comment (over 100). Where sample sizes were not large enough, subgroups have been combined (for example, number of years registered) to create a larger group.

It should also be borne in mind that certain subgroups overlap, such as age, dental professional group and the number of years registered with the GDC. For example, dental nurses have only been registered with the GDC since 2008, but their views may differ due to their role or due to the number of years they have been registered.

Throughout this report, registrants who took part in the online survey are referred to as 'respondents'.

[1] Other examples of varying sampling tolerances:
See Question 26 (p.58, Figure 27), sample size 74, sampling tolerance of +/- 11.4%
See Question 9 (p.25, Figure 9), sample size 1,320, sampling tolerance of +/- 2.7%
See Question 8 (p.23, Figure 7), sample size 3,611, sampling tolerance of +/- 1.6%

1.7 Interpretation of the qualitative findings

When interpreting qualitative research findings, which for this research have been collected via focus groups and in depth interviews, it is important to remember that these findings differ to those collected via a quantitative methodology. Qualitative findings are collected by speaking in much greater depth to a select number of participants (in this case, 70 GDC registrants).

Therefore it should be remembered that qualitative findings are not meant to be statistically accurate, robust or representative, but instead are collected to provide additional insight and greater understanding based on in depth discussion and deliberation, something not possible to achieve via a quantitative survey. For example, if the majority of participants in a series of focus groups hold a certain opinion, this does not necessarily apply to the majority of GDC registrants.

Throughout this report, registrants who took part in qualitative research (focus groups or in depth interviews) are referred to as 'participants'.

2. Research Findings

This section of report presents the detailed research findings for the Annual Survey of Registrants 2013. The findings follow the results of the quantitative online survey, which are then supported where relevant by qualitative evidence from the focus groups and in depth interviews. The results of the online survey are presented in tables, charts and percentages. The findings from the qualitative research are illustrated by direct quotations where appropriate. Enventure has also supplied the GDC with a full set of data tables related to the survey. These will be published on the GDC website.

The views expressed in this report are those of Enventure Research and not necessarily shared by the General Dental Council.

2.1 Online Survey Respondent Profile

2.1.1 Registrant group and setting

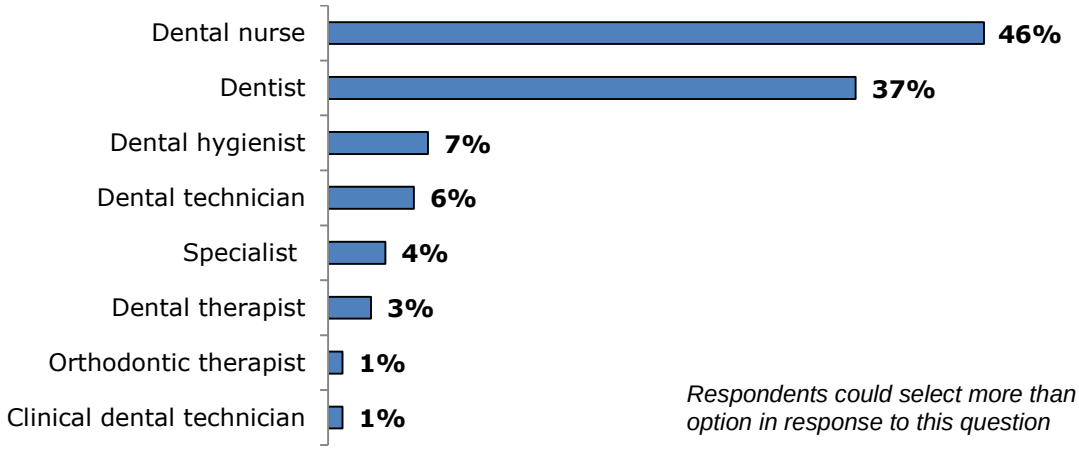
As the sample from the GDC registrant database was drawn using stratified random sampling, those who responded to the online survey were generally representative of the GDC registrant profile in terms of gender, age, registrant group and number of years registered. The results have been weighted to ensure that the achieved final sample is as representative as possible.

Data about ethnicity collected by the GDC is incomplete as it has not been compulsory for registrants to supply this to the GDC when registering. As a result, it is not possible for the sample to be representative in terms of ethnicity. However, a question relating to ethnicity was asked of all respondents. Therefore, the survey has been able to collect some useful information about the ethnic breakdown of the GDC register.

Respondents were asked to state what their role was, and could select more than one role if appropriate. As can be seen below in **Figure 1**, the largest group to respond to the survey was dental nurses at 46%, the largest group of DCPs (DCPs now make up the majority of GDC registrants). Almost two in five respondents were dentists (37%).

Almost a third of dentists had been registered with the GDC for 21 years or more (30%), whereas the majority of DCPs had been registered between 3 and 5 years (46%). However, it is important to remember that GDC registration was only made compulsory for certain groups of DCPs in 2008 who were not already registered (dental nurses and technicians, orthodontic therapists and clinical dental technicians), which reflects the stark difference in the amount of time registered.

Figure 1 – Dental professional role
Base: All respondents (3,611)



Respondents could select more than one option in response to this question

Respondents who indicated that they were a specialist were asked to specify what area they specialised in from the GDC's 13 specialist lists, the most common being Orthodontics (31%).

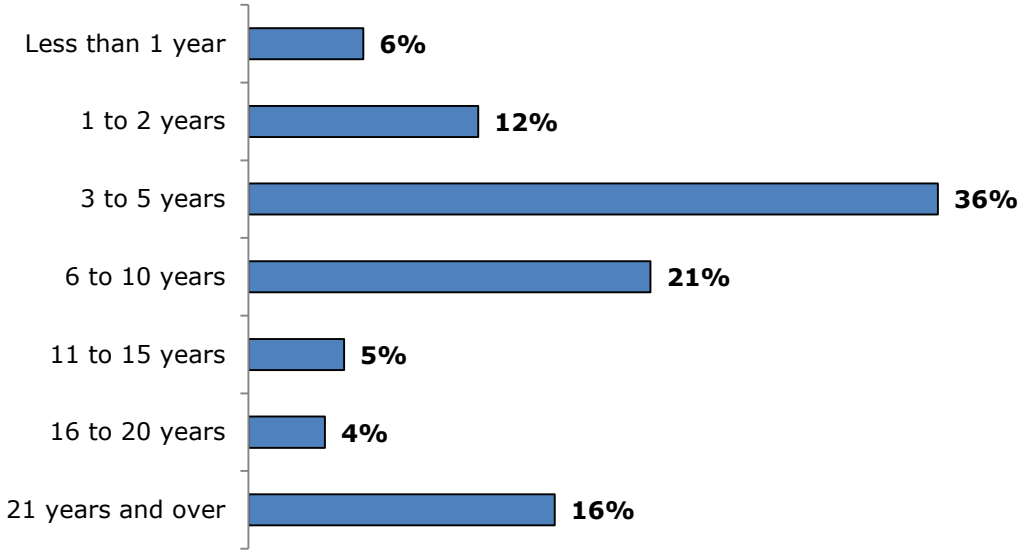
Table 2 – Specialist roles
Base: Specialists (146)

Specialism	Percentage
Orthodontics	31%
Oral Surgery	21%
Periodontics	9%
Restorative Dentistry	8%
Prosthodontics	7%
Special Care Dentistry	6%
Paediatric Dentistry	6%
Dental Public Health	6%
Endodontics	4%
Oral & Maxillofacial Pathology	2%
Oral Medicine	1%
Oral Microbiology	0%
Dental & Maxillofacial Radiology	0%
Other	11%

'Other' common specialist areas suggested included Oral & Maxillofacial Surgery (9 respondents), Oral Health Promotion (2 respondents) and Temporomandibular Joint (TMJ) Therapy (2 respondents).

Figure 2 below shows the number of years respondents had been registered with the GDC. Just over a third had been registered with the GDC for between 3 and 5 years (36%). The majority of these respondents were DCPs (77%), again reflecting their recent registration with the GDC.

Figure 2 – How long have you been on the GDC register?
Base: All respondents (3,611)



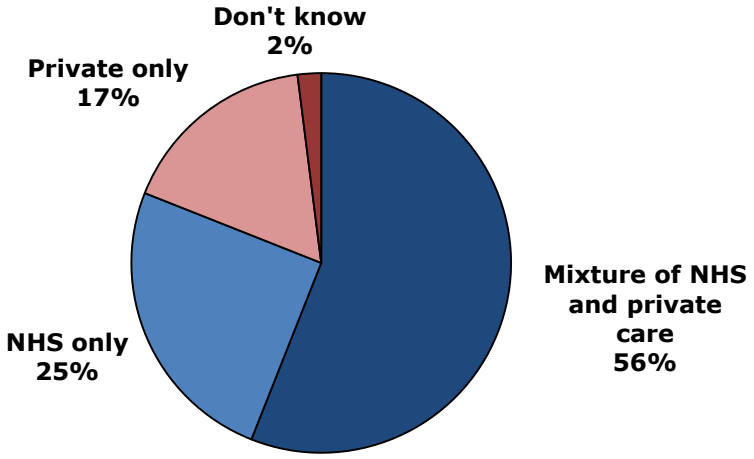
Overall, the majority of respondents provided a mixture of NHS and private care (56%), with a quarter providing NHS only (25%), and 17% private only. These results are shown in **Figure 3**. No significant changes can be seen when comparing these results to the 2012 and 2011 survey results.

Both dentists and DCPs were most likely to provide a mixture of NHS and private care, but a slightly larger proportion of dentists indicated that they provided a mixture (58%), where as a slightly larger proportion of DCPs indicated that they provided private only care (19%). In particular, a larger proportion of dental hygienists worked in private only care (52%), and a larger proportion of dental nurses worked in NHS care only (28%) in comparison to other dental professional groups.

In relation to country, a greater proportion of respondents who lived in Scotland provided NHS care only (45%) with just 4% indicating that they provided private care only. Also a greater proportion of respondents who lived in Northern Ireland provided a mixture of NHS and private care (73%), with just 1% stating that they provided private care.

Asian or Asian British and Black or Black British respondents were more likely to provide a mixture of NHS and private care at 73% and 69% respectively.

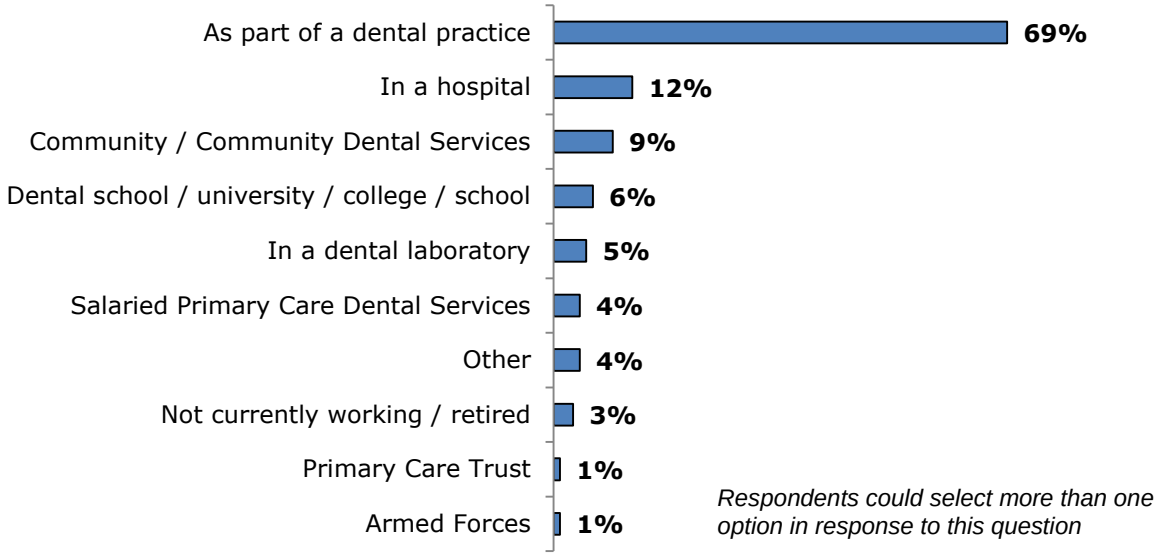
Figure 3 – What type of dental care do you provide?
Base: All respondents (3,611)



The majority of respondents indicated that they worked as part of a dental practice (69%). One in eight worked in hospitals (12%) and a further 9% worked within the community/community dental services. This is shown in **Figure 4** overleaf.

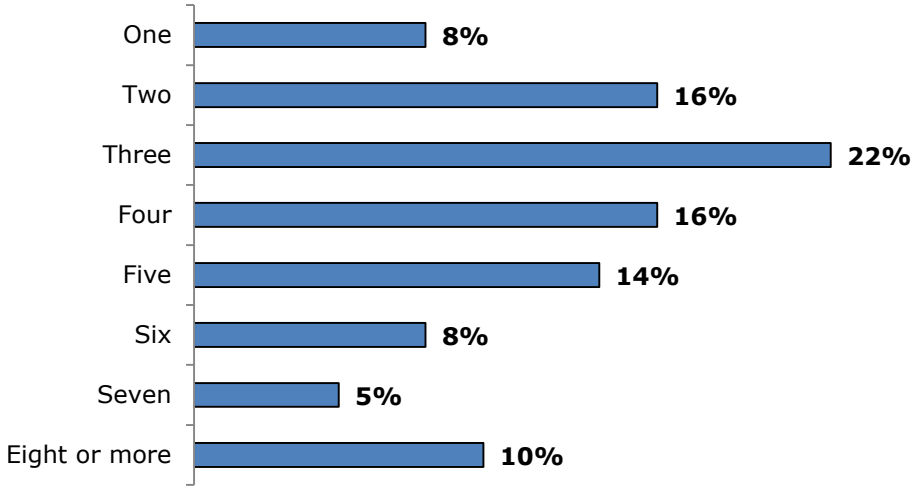
A larger proportion of hygienists (89%), therapists (83%) and dentists (77%) indicated that they worked as part of a dental practice, whereas a larger proportion of specialists worked in a hospital (40%). Compared to other dental professional groups, a larger proportion of dental nurses (13%) and therapists (14%) worked in a community setting.

Figure 4 – Where do you work?
Base: All respondents (3,611)



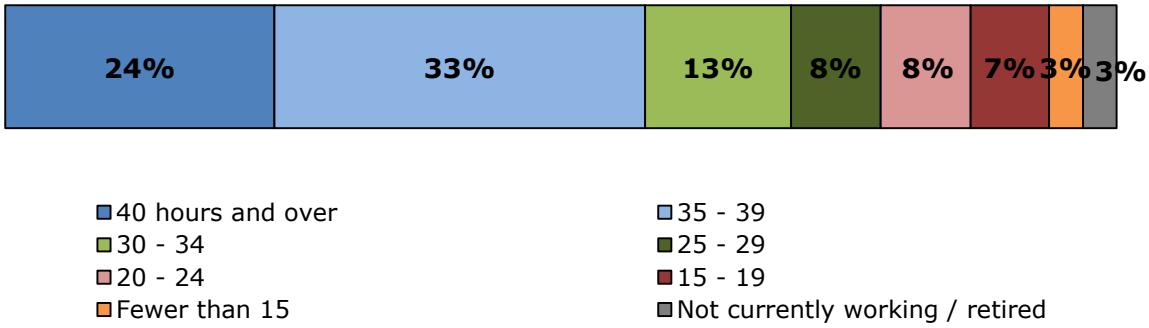
Respondents who indicated that they worked in a dental practice were asked how many dentists worked there. The range of responses can be seen in **Figure 5** below. Three quarters of respondents indicated that there were five dentists or fewer where they worked (a total of 76%).

Figure 5 – How many dentists (including yourself, if applicable) are there in the dental practice where you work?
Base: Respondents working as part of a dental practice (2,474)



A third of survey respondents worked between 35 and 39 hours per week (33%), and almost a quarter worked 40 hours and over (24%). These figures show very little change to those found in the 2012 results.

Figure 6 – Approximately how many hours per week do you normally work?
Base: All respondents (3,611)



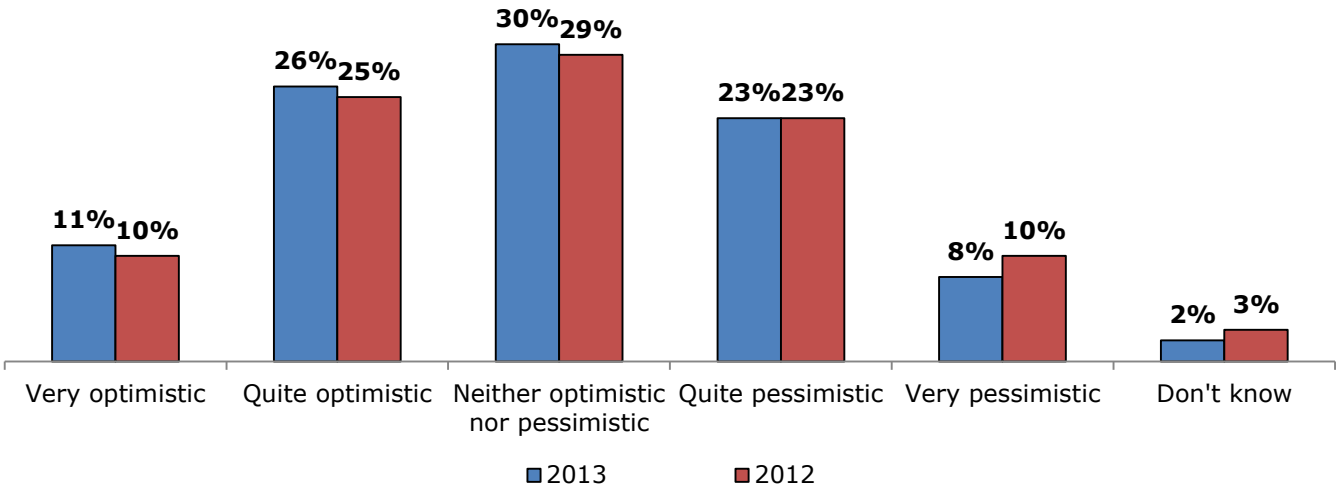
2.2 The Future, Challenges and Levels of Regulation

2.2.1 Optimistic or pessimistic?

In 2012, the Annual Survey of Registrants included questions which gained an understanding of how registrants were feeling about the future of their profession and to act as a general temperature check, in order to horizon scan for any emerging issues dental professionals may have been facing or were concerned about. The same questions were asked in the 2013 Annual Survey to track attitudes and opinions about the future of the profession.

This year, as in 2012, opinion about the future of dentistry over the next two years appears to be quite split between those who are optimistic and those who are pessimistic. Whilst almost two in five survey respondents indicated that they were in some way optimistic about the future (37% - a 2% increase from 2012), almost a third were in some way pessimistic (31% - a 2% decrease from 2012). A further 30% were neither optimistic nor pessimistic.

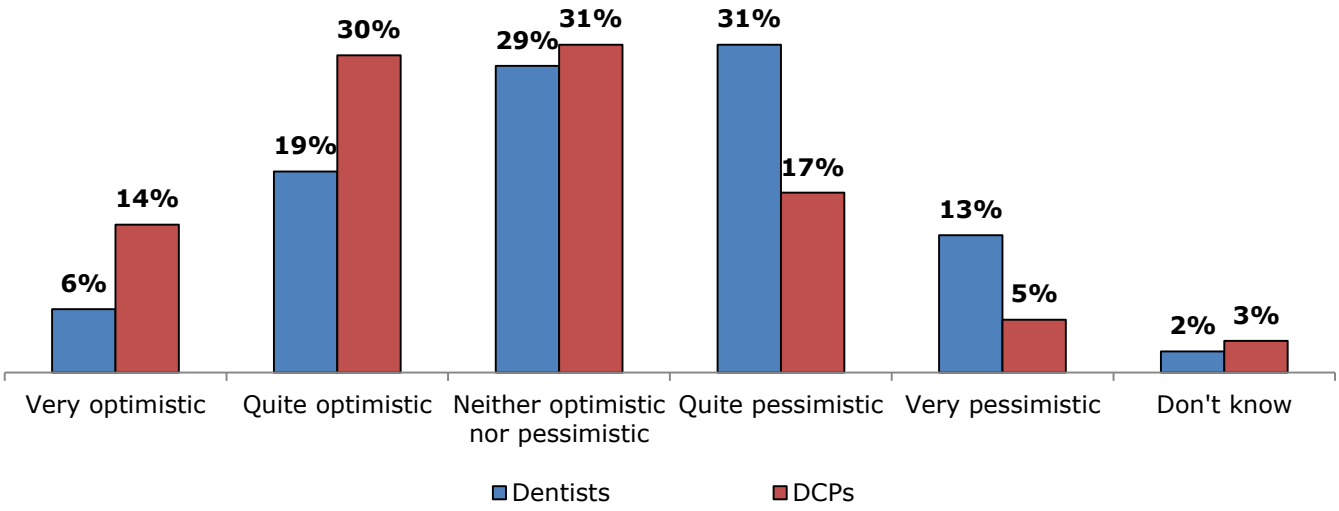
Figure 7 – Would you say you are optimistic or pessimistic about the future of your profession over the next two years?
Base: All respondents – 2013 (3,611) / 2012 (4,610)



Whilst small increases in levels of optimism and decreases in levels of pessimism can be seen (+/- 2%), this is only just outside the margin of error (+/- 1.6%) and therefore may only just be significant.

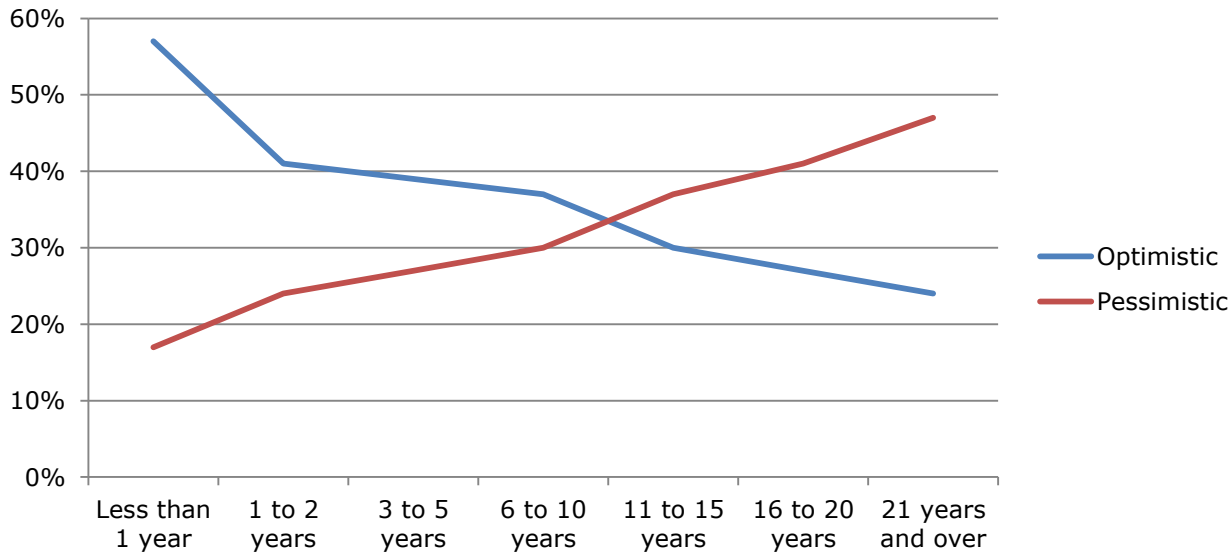
As shown in **Figure 8** overleaf, DCP respondents were generally more optimistic about the future (44% optimistic) when compared with dentists (25% optimistic). When looking at specific registrant groups, subgroup analysis highlights that larger proportions of certain respondents were more pessimistic than others, such as dentists (32% quite pessimistic / 13% very pessimistic), dental technicians (24% quite pessimistic / 11% very pessimistic), and those who had been registered with the GDC for a longer period of time. Male respondents were also more likely to be pessimistic at a total of 47% (compared to female respondents at 25%).

Figure 7 – Would you say you are optimistic or pessimistic about the future of your profession over the next two years?
Base: Dentists (1,408) / DCPs (2,203)



As seen in the 2012 survey results, the percentage of those who indicated that they felt pessimistic clearly increases and the percentage of those who indicated that they felt optimistic clearly decreases as the number of years registered increases, as shown in **Figure 9**.

Figure 9 – Levels of optimism and pessimism by years on the GDC register
Base: All respondents – 2013 (3,611)



Respondents who lived in Scotland were the most optimistic about the future at 42% (previously respondents who lived in Wales at 42% in 2012) compared with respondents who lived in Northern Ireland at 25% (again previously respondents who lived in Northern Ireland at 32% in 2012).

2.2.2 Areas of optimism

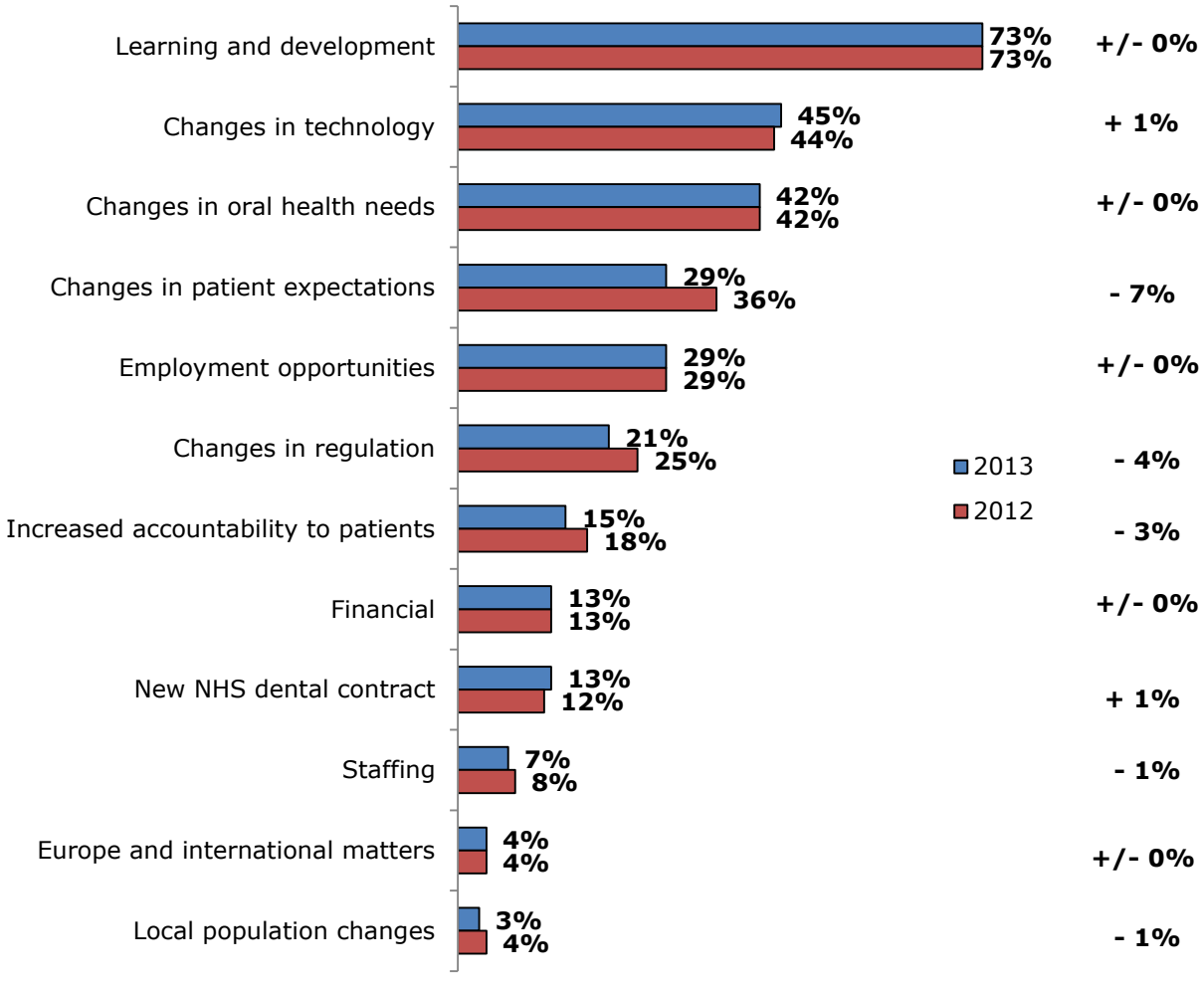
Those who indicated that they were optimistic about the future were asked what areas specifically they felt optimistic about. Survey respondents were able to select multiple options. **Figure 10** below presents the results to this question and also includes those collected in 2012, including the percentage difference between the 2012 and 2013 results shown on the right hand side.

Learning and development was by far the most popular suggestion at 73% in both 2013 and 2012. It is interesting to note that this was an area suggested by a larger proportion of dentists at 77%, but that this was an area suggested by a larger proportion of dental nurses in 2012 at 76%.

Changes in technology was suggested by over two in five respondents overall (45%, a 1% increase from 2012), and was considerably higher for dental technicians at 84%. Changes in oral health needs was suggested by just over two in five (42%) of respondents overall, but also by a larger proportion of dental hygienists at 50%.

Both changes in patient expectations and changes in regulation saw small decreases between 2012 and 2013 (-7% and -4% respectively), suggesting that they were not as widely seen as areas of optimism.

Figure 10 – What areas do you feel optimistic about?
Base: Respondents who are optimistic about the future – 2013 (1,320) / 2012 (1,450)



Respondents who were optimistic about the future were additionally asked to rank the areas which they had selected as feeling optimistic about in terms of importance (where 1 was the most important).

The areas are listed below in **Table 3** in terms of importance, based on the mean score recorded. The mean is calculated in the same way that an average score is calculated, by finding the sum of all the scores and dividing by the number of scores provided. Areas with a lower mean score were seen as more important, and those with a higher mean score were seen as less important. The results from the 2012 survey have been included for comparison.

Learning and development was seen as the most important area to feel optimistic about which recorded a mean score of 1.8, followed by changes in oral health needs at 2.3. In comparison to the 2012 results, little variation can be seen showing that importance has been given to similar areas in 2013.

Table 3 – Ranking of importance of optimistic areas within the dental profession over the next two years
Base: Respondents who are optimistic about the future – 2013 (1,320) / 2012 (1,450)

Area	Mean score 2013	Mean score 2012	Difference
Learning and development	1.8	1.7	- 0.1
Changes in oral health needs	2.3	2.3	-
Changes in patient expectations	2.4	2.5	+ 0.1
Changes in regulation	2.7	2.5	- 0.2
New NHS dental contract	2.8	2.7	- 0.1
Changes in technology	2.8	3.0	+ 0.2
Financial	2.9	3.5	+ 0.6
Increased accountability to patients	3.0	3.1	+ 0.1
Employment opportunities	3.1	2.9	- 0.2
Staffing	3.9	3.9	-
Europe and international matters	4.4	4.1	- 0.3
Local population changes	4.6	4.8	+ 0.2

2.2.3 Areas of pessimism

Respondents who indicated that they felt pessimistic about the future were also asked to specify which areas they were thinking of. Survey respondents were able to select multiple options. **Figure 11** overleaf shows that the majority of these respondents focused on changes in regulation (62%), financial issues (61%) and the new NHS dental contract (54%).

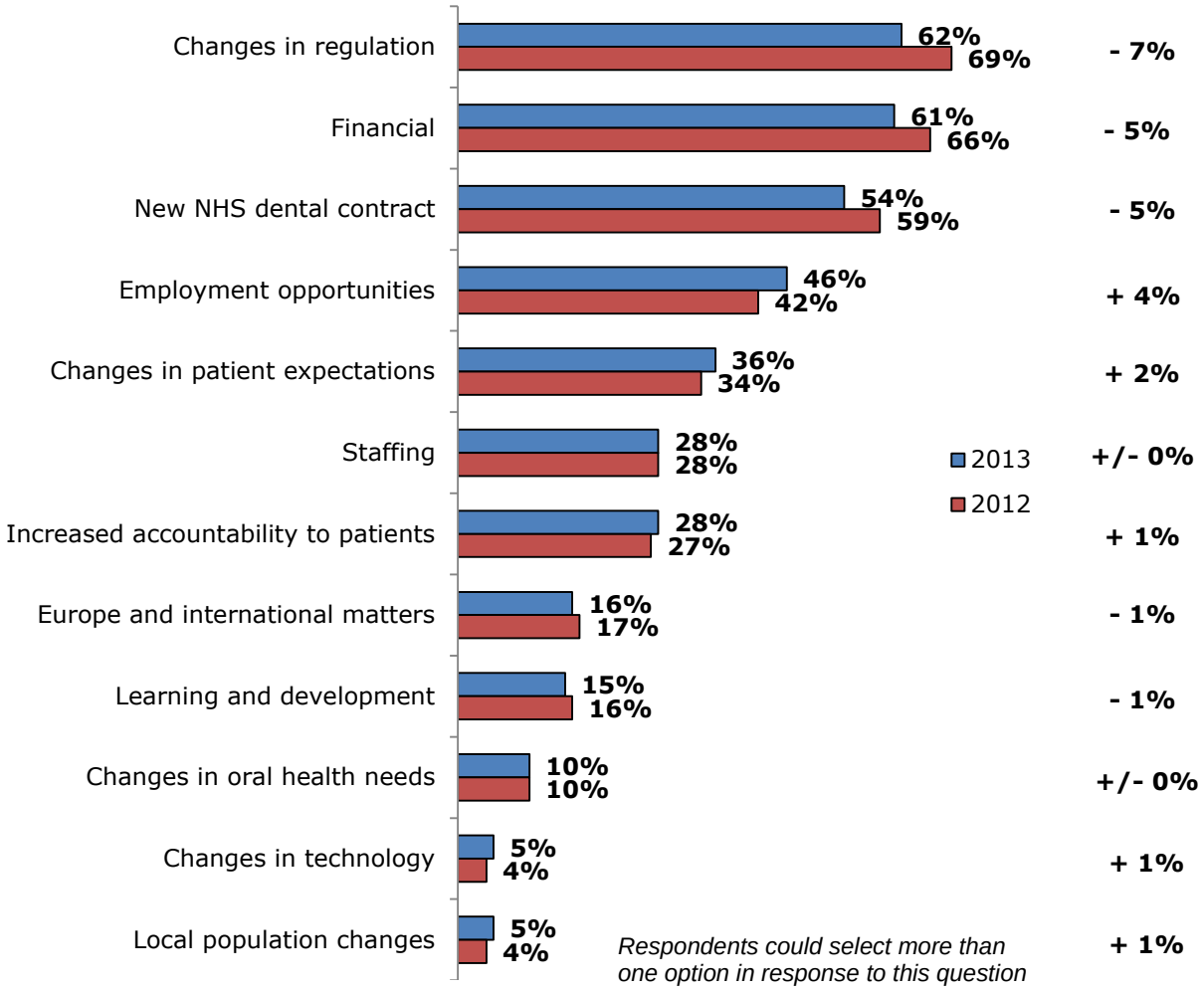
It is interesting to note that, whilst the same topics were most commonly suggested as areas of pessimism, each was suggested by a smaller proportion of respondents when compared to the 2012 results (changes in regulation -7%, financial -5%, new NHS dental contract -5%).

All of these areas were suggested by a larger number of dentists in comparison to DCPs at 72%, 65% and 71% respectively, again highlighting that a larger proportion of dentists felt pessimistic about the future.

A significantly larger proportion of DCPs suggested learning and development as an area that they felt pessimistic about at 26%. In particular, this was suggested by dental nurses (29%) and technicians (32%).

A larger proportion of respondents who had been registered with the GDC for over 16 years suggested changes in regulation as an area of pessimism at 73%. Those who had been registered for less than a year were more likely to suggest financial, employment opportunities and learning and development as areas of pessimism at 73%, 78% and 22% (compared to 61%, 46% and 15% overall).

Figure 11 – What areas do you feel pessimistic about?
Base: Respondents who are pessimistic about the future – 2013 (1,113) / 2012 (1,380)



Again, these respondents were additionally asked to rank the areas which they had selected as feeling pessimistic about in terms of importance. As seen in **Table 4** overleaf, the most widely selected areas of financial issues, the new NHS dental contract and changes in regulation were also seen as most important, all with similar mean scores. Employment opportunities were also seen as an important area to feel pessimistic about with a mean score of 2.8.

When compared to the 2012 results to this question, little change can be seen. The greatest differences seen are small increases in importance of changes in patient expectations (+0.4) and local population changes (+0.4), and a small decrease in importance of Europe and international matters (-0.4).

Table 4 – Ranking of pessimistic areas within the dental profession over the next two years
Base: Respondents who are pessimistic about the future – 2013 (1,113) / 2012 (1,380)

Area	Mean score 2013	Mean score 2012	Difference
Financial	2.4	2.3	- 0.1
New NHS dental contract	2.4	2.4	-
Changes in regulation	2.5	2.3	- 0.2
Employment opportunities	2.8	2.8	-
Learning and development	3.1	3.3	+ 0.2
Changes in patient expectations	3.2	3.6	+ 0.4
Increased accountability to patients	3.3	3.2	-0.1
Staffing	3.5	3.4	- 0.1
Europe and international matters	4.0	3.6	- 0.4
Changes in oral health needs	4.1	4.1	-
Changes in technology	4.4	4.7	+ 0.3
Local population changes	5.0	5.4	+ 0.4

To allow for comparison between key areas of optimism and pessimism, both sets of results have been displayed below in **Figure 12**.

Figure 12 – What areas do you feel optimistic / pessimistic about?
Base: Respondents who are optimistic about the future (1,320) / Respondents who are pessimistic about the future (1,113)

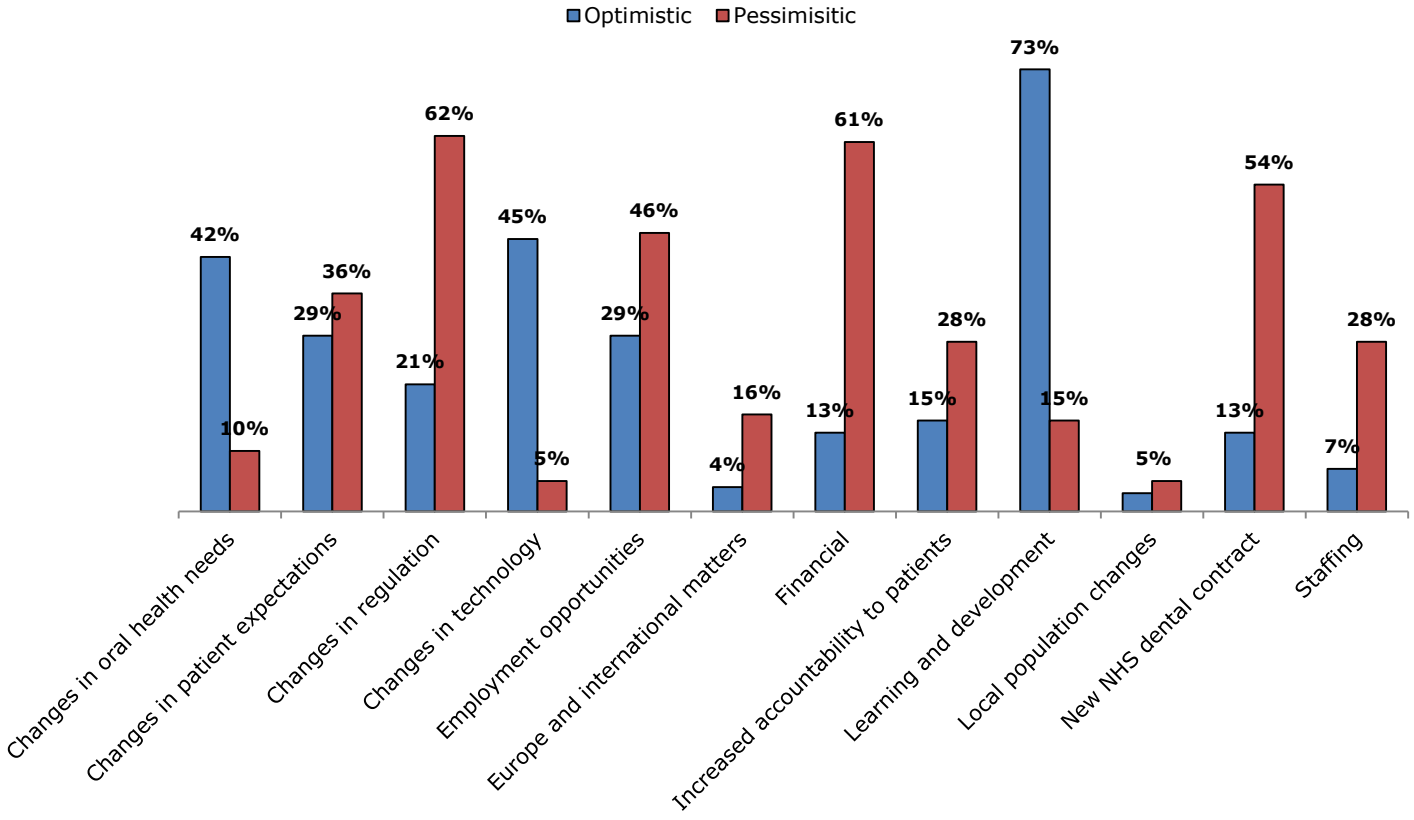


Table 5 presents the net values of optimism/pessimism, calculated by finding the difference between the percentage who felt optimistic and the percentage who felt pessimistic about each area. Positive values indicate areas of optimism, whereas negative values indicate areas of pessimism.

Table 5 – Net values of optimism/pessimism

Area	Net optimism/pessimism value
Learning and development	58%
Changes in technology	40%
Changes in oral health needs	32%
Local population changes	- 2%
Changes in patient expectations	- 7%
Europe and international matters	- 12%
Increased accountability to patients	- 13%
Employment opportunities	- 17%
Staffing	- 21%
Changes in regulation	- 41%
Financial	- 48%
New NHS dental contract	- 67%

2.2.4 Challenges

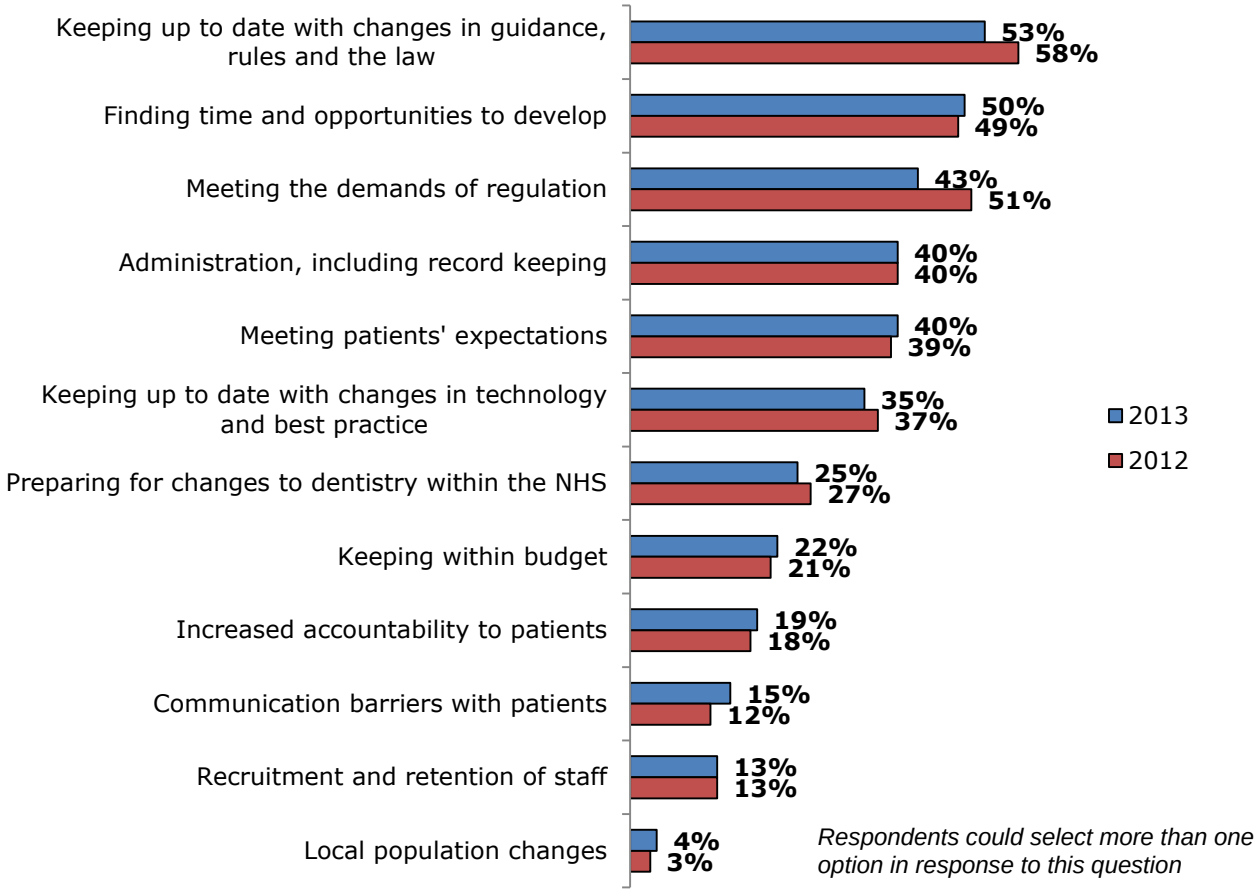
All survey respondents were asked to indicate what they felt were the greatest challenges in their current daily practice. Survey respondents were able to select multiple options and the results are shown in **Figure 13** below. Just over half suggested keeping up to date with changes in guidance, rules and the law (53%), closely followed by finding time and opportunities to develop at 50%.

It is interesting to note that the proportion of respondents selecting meeting the demands of regulation has fallen significantly between 2012 and 2013 from 51% to 43%. Similarly, keeping up to date with changes in guidance, rules and the law has also fallen by 5% between 2012 and 2013 (58% to 53%).

Subgroup analysis shows that DCPs were more likely to suggest that finding time and opportunities to develop was a challenge at 55% (compared to dentists at 43%), particularly dental technicians at 60%. A larger proportion of dentists suggested meeting the demands of regulation as a challenges at 50%, something which was suggested by far fewer DCPs, particularly dental therapists (30%).

Significantly fewer respondents living in Scotland suggested meeting the demands of regulation as a challenge within their current daily practice at 38%, and fewer respondents living in Wales suggested keeping up to date with changes in guidance, rules and the law at 46%.

Figure 13 – What are the greatest challenges in your current daily practice?
Base: All respondents – 2013 (3,611) / 2012 (4,160)



Respondents were asked to rank the challenges they had selected to indicate which they felt were the most challenging, shown in **Table 5**. Keeping up to date with changes in guidance, rules and the law was ranked as the most challenging with a mean score of 2.6, followed by meeting the demands of regulation and finding time and opportunities to develop (both with a mean score of 2.7).

When comparing these rankings to those collected in 2012 little change can be seen.

Table 5 – Ranking of challenges
Base: Respondents who indicated challenges 2013 (3,505) / 2012 (4,037)

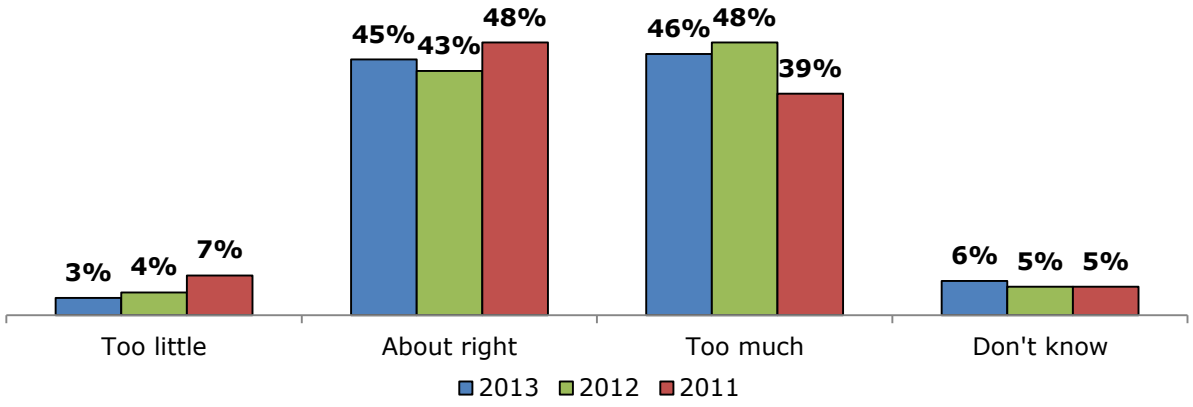
Challenge	Mean score 2013	Mean score 2012	Difference
Keeping up to date with changes in guidance, rules and the law	2.6	2.5	- 0.1
Meeting the demands of regulation	2.7	2.5	- 0.2
Finding time and opportunities to develop	2.7	2.8	+ 0.1
Meeting patients' expectations	2.8	2.8	-
Administration, including record keeping	2.9	3.1	+ 0.2
Keeping up to date with changes in technology and best practice	3.3	3.3	-
Keeping within budget	3.3	3.2	- 0.1
Recruitment and retention of staff	3.4	3.5	+ 0.1
Preparing for changes to dentistry within the NHS	3.5	3.4	- 0.1
Increased accountability to patients	4.0	4.1	+ 0.1
Communication barriers with patients	4.0	4.0	-
Local population changes	5.1	4.5	- 0.6

2.2.5 The overall level of regulation

Survey respondents were asked to indicate whether they felt the level of regulation of dentistry was about right, too little or too much. As can be seen in **Figure 14** below, almost the same proportion of respondents indicated that they thought the level of regulation was about right (45%) or too much (46%). Just 3% felt that the level of regulation was too little.

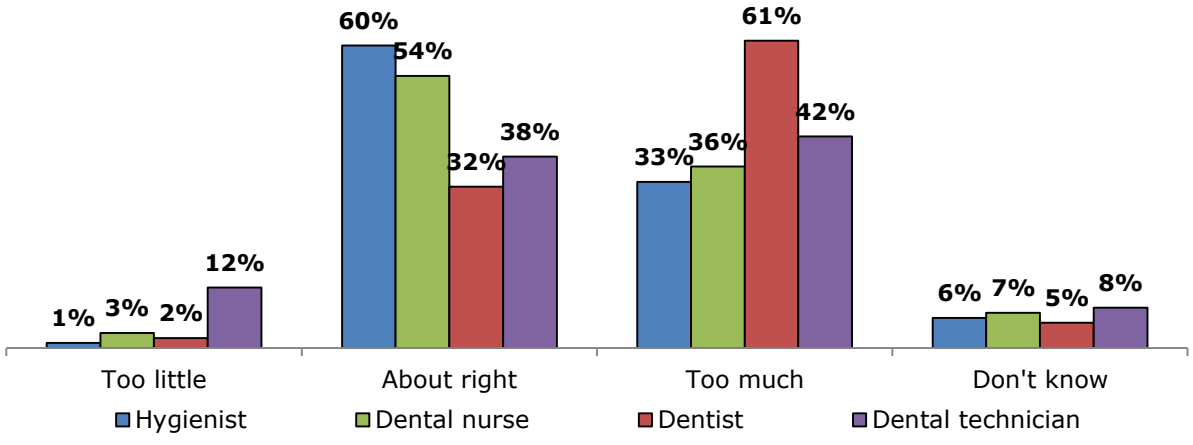
In comparison to previous survey results, a slight increase in the level of registrants who indicated that the level of regulation is about right can be seen (+2%) at the expense of those who saw the level as too much (-2%). This contrasts to the results collected between 2011 and 2012, which saw an increase in the proportion of respondents who indicated that the level of regulation was too much and a decrease in the proportion who thought it was about right. However, it should be noted that these small percentage differences are only just outside the margin of error (+/- 1.6%) and therefore may not be significant changes of opinion.

Figure 14 – Thinking in general about the overall regulation of dentistry, do you think the level of regulation is…?
Base: All respondents 2013 (3,611) / 2012 (4,160) / 2011 (2,827)



Looking across the subgroups for the 2013 results (**Figure 15**), a larger proportion of DCPs said that the level of regulation was about right, in particular dental hygienists (60%) and nurses (54%). This contrasts starkly to the opinion of dentists, where just 32% indicated that the level of regulation was about right and the majority at 61% said that it was too much. As seen in the 2012 results, again a greater proportion of dental technicians indicated that it was too little at 12% (compared to just 3% overall).

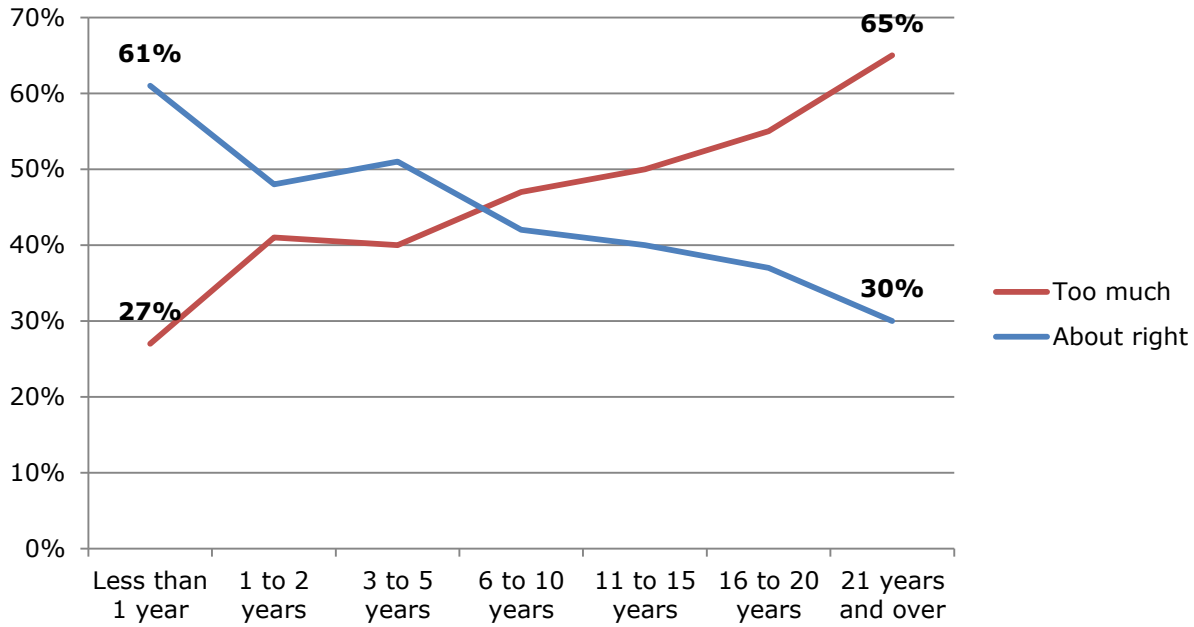
Figure 15 – Thinking in general about the overall regulation of dentistry, do you think the level of regulation is…?
Base: Hygienists (261) / dental nurses (1,648) / dentists (1,324) / dental technicians (219)



A larger proportion of male respondents indicated that regulation levels were too much at 62%, compared to female respondents at 40%, as did a larger proportion of respondents from an Asian/Asian British background at 61%. Respondents who lived in Scotland were more inclined to state that levels of regulation were about right at 54% compared to other areas.

As seen in 2012, the number of years on the GDC register also has a significant impact on the results to this question, with the proportion of respondents indicating that regulation is about right falling as the years increase (from 61% to 30%), and conversely the proportion of respondents indicating that regulation is too much increasing (from 27% to 65%). This finding is shown in **Figure 16** below.

Figure 16 – View of the level of regulation by years on the GDC register
Base: All respondents (3,611)



Qualitative findings

This year the survey results have highlighted that registrants may be feeling slightly more positive about levels of regulation when compared to the results collected in 2012. These results include:

- 'Changes in regulation' has decreased as an area of pessimism from 69% to 62%
- 'Keeping up to date with changes in guidance, rules and law' has decreased as a challenge of daily practice from 58% to 53%
- 'Meeting the demands of regulation' has decreased as a challenge of daily practice from 51% to 43%
- A larger proportion of respondents stated that levels of regulation were 'about right' from 43% to 45%

These results were used to stimulate discussion in both focus groups and in depth telephone interviews in order to explore in detail registrants' attitudes towards current levels of regulation and why they had these views.

Those who felt that current levels of regulation were too high

In the main, attitudes towards regulation expressed in the qualitative research did not suggest that registrants were feeling more optimistic or positive about levels of regulation. Participants in both focus groups and in depth interviews tended to express the opinion that current levels of regulation were too high, providing various reasons why they held this view. One of the most common reasons provided was that regulation had become so excessive, with increasing levels of paperwork, that it made their job increasingly challenging on a daily basis. These participants felt that regulation was essentially increased red tape and box ticking exercises which they felt may not necessarily provide any tangible benefit to the profession.

> *It's becoming more and more. My daily job is no longer doing teeth, it's getting through red tape and meeting requirements.*
>
> (Dentist, focus group, Leeds)

> *Paperwork is now more important than the mechanics of doing your job, and that's what regulation is all about – paperwork.*
>
> (Clinical dental technician, depth interview, England)

Some participants went on to explain that they found the current levels of regulation so high that they came across as patronising, making them feel as though they were not trusted as professionals to deliver care to patients to a high standard. Others explained that they felt that high levels of regulation made them feel as though they were trying to be 'caught out', found to be doing something wrong, even though they are doing their best to provide high levels of care. It was suggested that GDC regulation now went too far to encourage patients to complain, regardless of the seriousness of the complaint, and therefore created the perception amongst some dental professionals that regulation was bordering on persecution.

> *Before you just got on with things and did it correctly, but now someone is telling me I have to do things. It can be a bit patronising and there is too much.*
>
> (Dentist, depth interview, Northern Ireland)

> *In dentistry now everyone is treated like they've done something wrong or they're about to. There's no respect for professionals.*
>
> (Dentist, depth interview, Northern Ireland)

Whilst this large proportion of focus group and in depth interview participants felt that levels of regulation were too much, it was universally accepted that high levels of regulation were required in the profession of dentistry, but at the same time generally felt that the current levels of regulation were infringing on their ability to provide a high level of care.

> *You've got to have it. I don't think anyone would dispute that you've got to have regulation of the profession. But when it comes to the point where it becomes impossible to get anything done it becomes counterproductive for the patients.*
>
> (Dentist, focus group, Leeds)

> *There has to be some regulation obviously, but it's getting more and more prescriptive and there's not a lot of freedom anymore.*
>
> (Dentist, depth interview, Northern Ireland)

Those who felt that current levels of regulation were about right

Not all participants felt that levels of regulation were too high. A smaller but significant number of participants, including a larger number of dental nurses, indicated that they thought the current level of regulation of dentistry was about right. These participants

generally explained that they were happy with the current levels of regulation, stating that they did not infringe on their ability to practise, and focused on the benefits of regulation for both the patient and the dental professional, explaining that regulation was necessary to ensure all dental professionals were providing the highest standard of care.

> *All health care professionals should work to a high standard. It can feel like a faff at times but it's important. You have to be aware of changes for patient safety to treat them as best you can. Paperwork can be time consuming but it's for the greater good.*
>
> (Dental nurse, depth interview, England)

> *I personally don't find any of the regulations a particular hindrance, they make you work to a professional level and make you more aware of what you're doing and what the repercussions can be.*
>
> (Dental technician, focus group, Nottingham)

Some of these participants explained that they could understand why some dental professionals found regulation frustrating at times, but took a more pragmatic approach to regulation, stating that working within new rules eventually became a habit and easier over time. It was suggested that those who were newer to the profession would find it easier to work within the current levels of regulation as they would not know what the situation was like before and would also have been trained to work with similar levels of regulation, whereas dental professionals who have been working in the field for many years may find it harder to adjust and therefore may find regulation more challenging.

> *Regulation is good. We need it to do a good job and provide a good service at a high standard. Yes new regulation can make things difficult at first, but it becomes a habit and gets easier. You've got to think of the bigger picture and the benefits to patients.*
>
> (Dental nurse, depth interview, Wales)

> *I think newly qualified dentists will not have a problem with regulation as they're used to it. It's the older ones who find it flummoxing. It's harder for those with more experience to adapt.*
>
> (Dentist, depth interview, Wales)

> *It's no problem for the younger dentists as they're already used to it, paperwork and regulations are part of the training. The older dentists are more set in their ways.*
>
> (Dentist, depth interview, Scotland)

Other organisations

All participants were aware that the GDC was responsible for the regulation of dentistry. However, as a result of devolution, when asked whether there was clarity within dental regulation, a large proportion of participants explained that they were confused by the existence of other organisations such as the Care Quality Commission (CQC) in England, the Healthcare Inspectorate Wales (HIW) in Wales, the Regulation and Quality Improvement Authority (RQIA) in Northern Ireland and the National Dental Advisory Committee (NDAC) in Scotland and exactly what role they played alongside the GDC. It was felt that having more than one organisation responsible for regulation in each country created significant overlap and confusion amongst dental professionals and patients. This confusion also suggests that registrants are not clear on the GDC's role and what it is responsible for, leading to a lack of understanding about the differences between these organisations.

Why do we need so many layers who all require the same information?
(Dentist, focus group, Cardiff)

As far as we see it the GDC are there to protect the patient and not us. The CQC are there to protect the patient and not us. It's like where does one end and the other begin?
(Hygienist, focus group, Leeds)

How do the GDC ensure that proper standards are being met? They don't seem to have anything to do with that, that isn't what they do is it?
(Dental technician, focus group, Reading)

Respondents in Wales specifically questioned why they were regulated by the HIW rather than the CQC, explaining that they felt this caused even more confusion and unnecessary bureaucracy. The example was provided that practices in Newport and Bristol are regulated by different organisations despite being just a few miles apart, and dental professionals who perhaps worked part time in two practices, one in England and one in Wales. It was felt that these regional differences created by devolution, in addition to multiple organisations, created a lack of clarity and consistency for both dental professionals and patients.

It's all about national politics and making a statement about Wales doing things differently. That's why we have HIW rather than CQC. How does the fact that we have inconsistent regulation and a lack of standardisation help anyone?
(Dentist, focus group, Cardiff)

It makes things very difficult. I know there are some things I can do in one country that I can't in another. It should be one rule for everyone.
(Hygienist, depth interview, Wales)

A common suggestion from participants who indicated that there was a lack of clarity in terms of regulation was that it was not necessary to have more than one organisation responsible for regulation of dentistry, and that having one regulator would make things clearer and simpler.

If you had one body doing it, it would make things easier. Rather than having different people coming at you from different angles.
(Dental nurse, focus group, Leeds)

In England you have the GDC and the CQC. Both are there to protect to patient, so shouldn't there just be one organisation? We don't have the CQC in Scotland and it's different in each country so it makes it difficult.
(Hygienist, depth interview, Scotland)

Proactive regulation

A small proportion of participants explained that they felt the GDC could do more to regulate the profession by taking a more proactive role. It was explained that, to truly understand how dental professionals work and whether they operate to the correct standard, they had to be observed. It was suggested by these participants only regulating reactively when responding to concerns raised by either patients or other dental professionals was not enough as it relied too heavily on the willingness of people to report concerns.

To regulate the profession they rely on backstabbing and shopping. It needs to be more proactive rather than just relying on complaints.
(Dental technician, depth interview, Scotland)

The GDC need to get out into a practice and into a lab and see exactly what is going on and how competent people are.

(Clinical dental technician, depth interview, England)

I'd feel good about more proactive regulation. I think the only way you can know if someone is a good dentist is to watch them. The GDC could observe dentists as it doesn't all come through in records and paperwork. That way they would have a better understanding of the dentist and could have more evidence to use if a concern is raised about them.

(Dentist, depth interview, England)

The purpose of regulation

When asked what they thought the purpose of regulation was, all participants explained that regulation was present in dentistry to protect the patient by ensuring that all dental professionals operate to the highest standards possible. It was felt that by doing this, regulation also protected the dental professional as it ensured that they abided by a common set of rules and did not abuse the profession.

It's about keeping patients safe and ensuring we're all performing our role. Not allowing any abuse of the system.

(Dental nurse, depth interview, Scotland)

It's for the patient's safety and your own at the end of the day. If you follow the rules and regulations then you'll have no problems and neither will your patients.

(Dental nurse, depth interview, Wales)

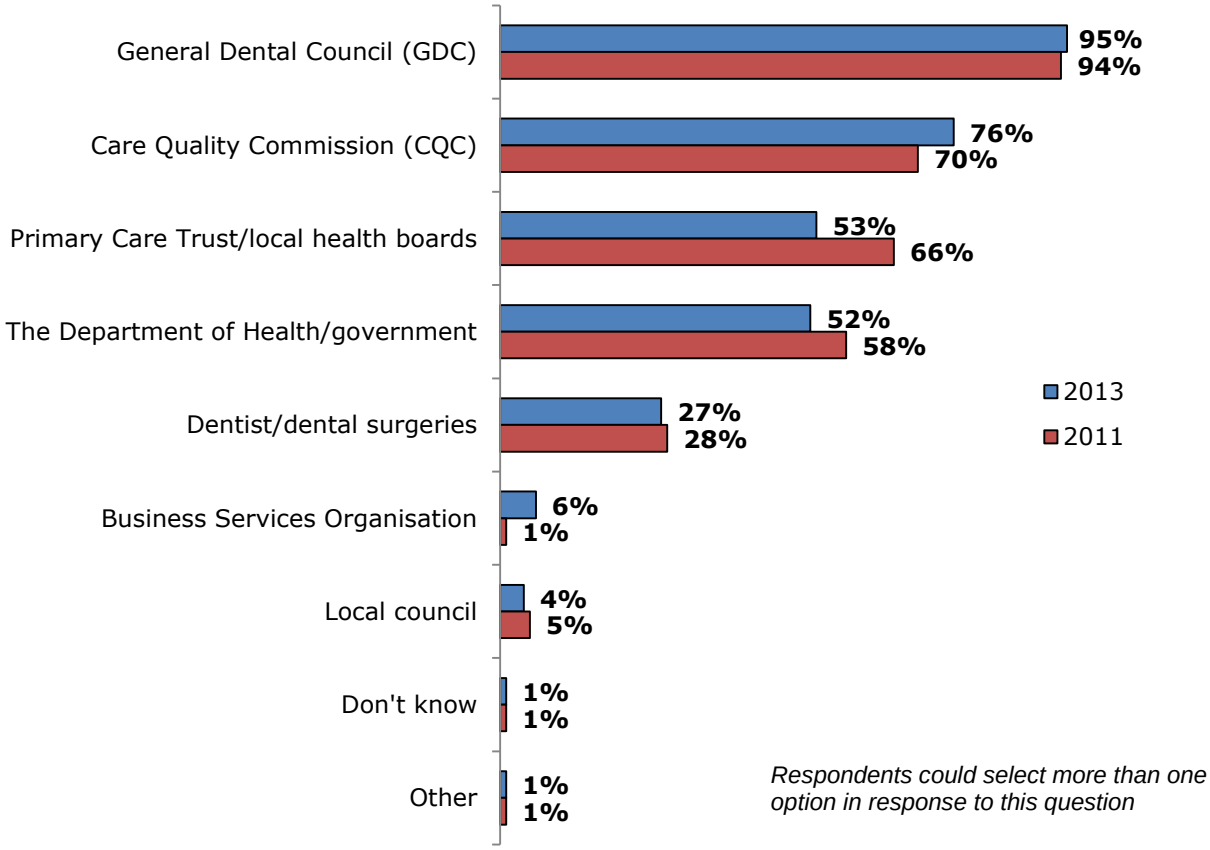
2.3 Perspectives on the GDC

2.3.1 Awareness of the GDC

All respondents were asked to suggest which organisations were currently responsible for regulating dentistry from a list of possible options. Survey respondents were able to select multiple options in answer to this question. As shown in **Figure 17** below, almost all respondents suggested the General Dental Council (GDC) at 95%, followed by a further three quarters of respondents who suggested the Care Quality Commission (CQC) (76%). Just over half of respondents selected Primary Care Trust/local health boards (53%) and the Department of Health/government (52%).

This question was previously asked in the 2011 Annual Survey of Registrants, which recorded similar results as shown in the chart below, with almost the same proportion of respondents suggesting that the GDC was responsible for regulating dentistry. A slightly larger proportion of respondents suggested the CQC in 2013 at 76% (compared to 70% in 2012), whereas a larger proportion of respondents suggested the Primary Care Trust or the Department of Health in 2012 at 66% and 58% respectively (compared to 53% and 52% in 2013).

Figure 17 – From what you know, which of the following organisations, if any, are currently responsible for regulating dentistry?
Base: All respondents – 2013 (3,611) / 2011 (2,827)



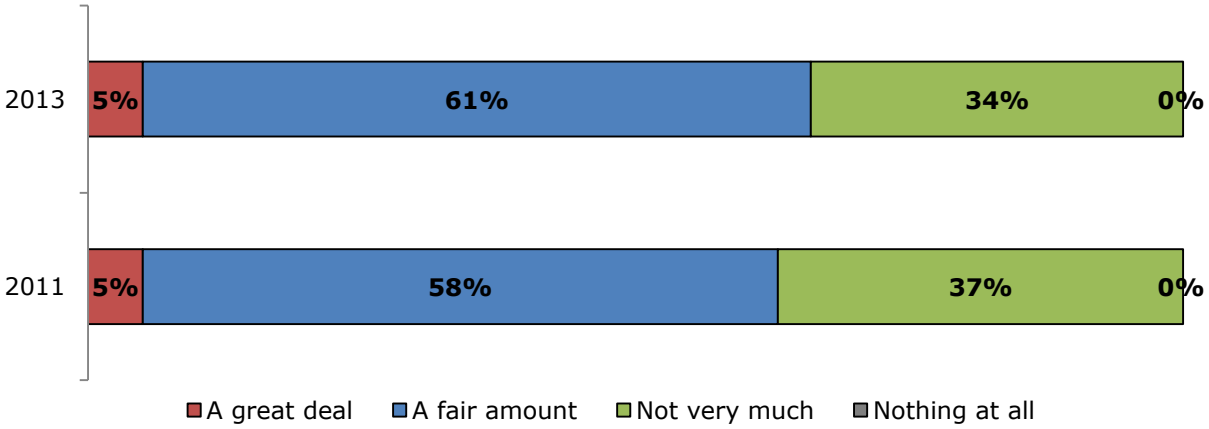
Subgroup analysis of the results to this question shows that a larger proportion of dentists (81%), dental hygienists (82%) and therapists (80%) suggested the CQC compared to 76% overall. Dentists were also more likely to suggest Primary Care Trust/local health boards at 63% (compared to 53% overall).

When comparing the results to this question to the GDC's Patient and Public Survey 2013, a significant difference between levels of awareness of the GDC amongst dental professionals and patients and the public can be seen, with just 25% of patients and the public suggesting the GDC as responsible for regulating dentistry compared to 95% of dental professionals.

Respondents were then asked to state how much they knew about the General Dental Council. **Figure 18** below shows that the majority of respondents were familiar with the GDC, as 61% said that they knew a fair amount and 5% that they knew a great deal about the GDC. However, a significant minority claimed that they knew not very much about the GDC (34%).

In comparison to the results from the 2011 Annual Survey of Registrants, an increase of 3% can be seen in those who knew a fair amount about the GDC, and a decrease in 3% of those who said they knew not very much. Whilst this it outside the overall margin of error (+/- 1.6%), it is important to remember that this is only a slight percentage change.

Figure 18 – How much do you know about the General Dental Council?
Base: All respondents – 2013 (3,611) / 2011 (2,827)



The sample highlights that dentists and specialists indicated that they were most informed about the GDC, as 7% of dentists and 8% of specialists stated that they knew a great deal (compared to 5% overall). A larger proportion of dental hygienists (70%) and therapists (68%) said that they knew a fair amount about the GDC. The largest proportion of respondents to indicate that they did not know very much about the GDC was dental nurses at 40% (compared to 34% overall), and 2% of dental technicians said that they knew nothing at all about the GDC (2% compared to less than 1% overall).

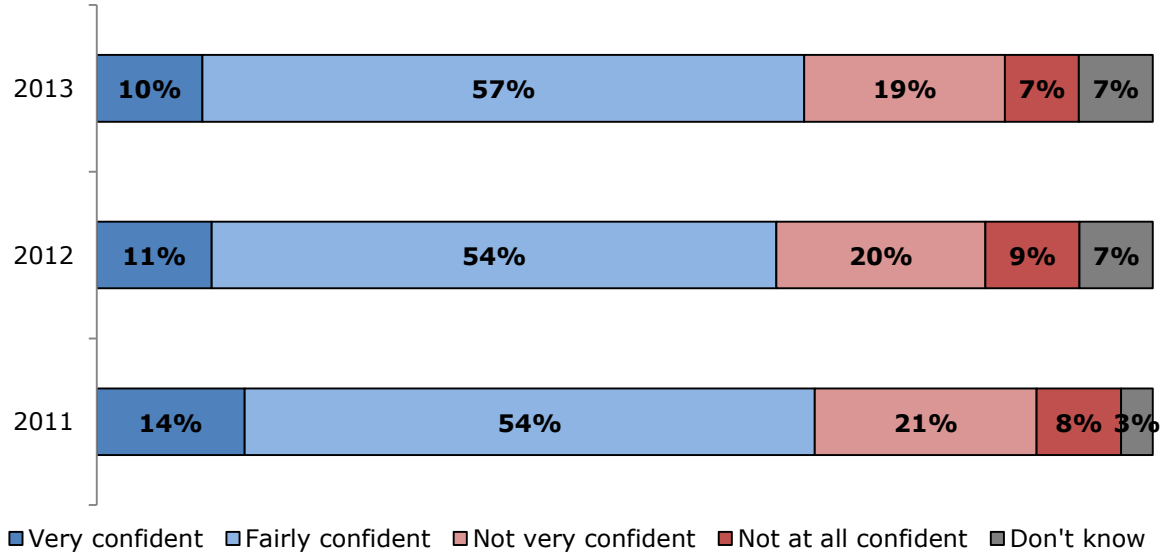
2.3.2 Confidence in the GDC and its guidance

Survey respondents were asked to indicate how confident they were, if at all, in the GDC's ability to regulate dentists and DCPs effectively.

The majority of respondents were in some way confident in the GDC's ability to regulate (a total of 67%), as 57% indicated that they were fairly confident and 10% that they were very confident. Just over a quarter (26%) said that they were not confident, with 19% not very confident and 7% not at all confident. These results are shown in **Figure 19** overleaf.

Figure 19 also presents the results collected in response to this question from the 2011 and 2012 Annual Survey of Registrants, showing that confidence levels have remained generally the same over the past three years. The most significant change is the proportion of respondents who indicated that they were very confident which has fallen slightly by 4% from 14% in 2011 to 10% in 2013.

Figure 19 – Overall, how confident, if at all, are you that the GDC is regulating dentists and DCPs effectively?
Base: All respondents – 2013 (3,611) / 2012 (4,160) / 2011 (2,827)



Differences in confidence levels can be seen between dental professional groups. A larger proportion of dental hygienists (81%), nurses (76%) and therapists (81%) were in some way confident in the GDC's effectiveness to regulate, whereas a significantly larger proportion of dental technicians indicated that they were not confident (a total of 57%).

A large difference in confidence can be seen between male and female respondents, with a total of 73% of female respondents confident compared to just 50% of male respondents. Respondents who live in Wales also have a higher confidence level at 73% (compared to 67% overall).

As seen in 2012, the number of years registered with the GDC again has an impact on responses to this question. As the number of years registered increases, the level of confidence in the GDC's effectiveness at regulating falls. Total confidence levels begin at 78% for those who have been registered for less than a year and steadily fall to 57% for those who have been registered for 21 years and over.

It is also interesting to look at the results to this question in relation to the Patient and Public Survey 2013, where overall confidence in the GDC's ability to regulate dental professionals was significantly higher amongst patients and the public, at 77% compared to dental professionals at 67% (a difference of 10%).

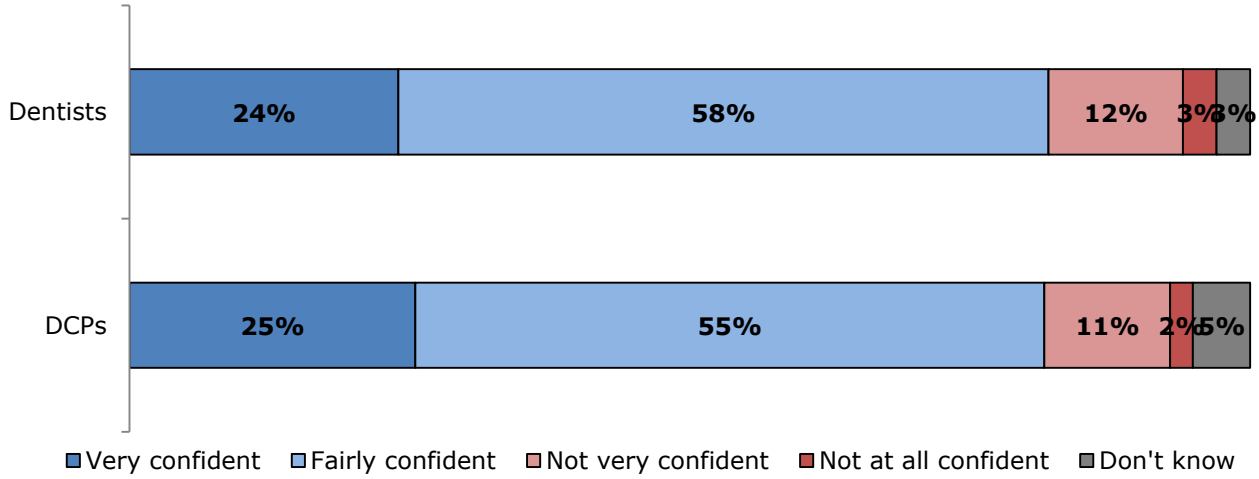
Respondents were then asked to state how confident they were that dentists and DCPs follow the guidance set by the GDC. As shown in **Figure 20**, the majority of respondents were confident that both dentists and DCPs followed the GDC's guidance.

A total of 82% of respondents were in some way confident that dentists followed the GDC's guidance (24% very confident, 58% fairly confident). One in seven respondents (a total of 15%) were in some way not confident. All dental professional groups recorded

similar results with the exception of dental technicians who were more likely to indicate that they were in some way not confident that dentists followed the guidance at 38% (compared to 15% overall).

Almost the same proportion of respondents were in some way confident that DCPs followed the GDC's guidance (25% very confident, 55% fairly confident). One in eight indicated that they were in some way not confident (a total of 13%), and a further 5% said that they did not know. Subgroup analysis highlights that a larger proportion of dental hygienists (96%) and therapists (97%) were confident that DCPs followed the GDC's guidance, particularly when compared to dental technicians (60%) and dentists (71%).

Figure 20 – Overall, how confident, if at all, are you that dentists / DCPs follow the GDC guidance?
Base: All respondents (3,611)



This question was also asked in the 2011 Annual Survey of Registrants, but only marginal changes can be seen. When comparing the results to the GDC's Patient and Public Survey 2013, a similar level of confidence can be seen, with 80% of patients and the public in some way confident (17% very confident, 63% fairly confident).

2.3.3 The reputation of the GDC

Continuing the theme of registrants' perspectives on the GDC, survey respondents were asked to indicate how they would speak of the GDC based on all they know about it. As seen in **Figure 21**, over two in five respondents (45%) indicated that they would remain neutral about the GDC, refusing to speak highly or speak critically. A quarter of respondents (25%) indicated that they would speak highly of the GDC *if asked* (prompted), however a further 14% said that they would be critical *if asked*. Just one in twenty respondents indicated that they would speak highly (5%) or critically (4%) of the GDC *without being asked* (unprompted).

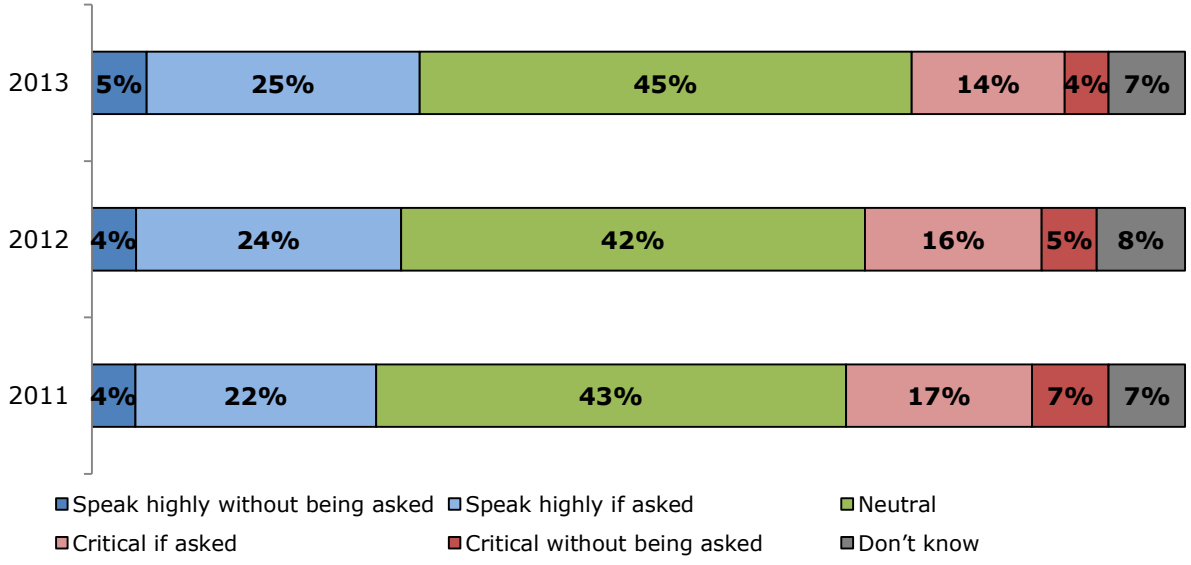
Figure 21 also presents the results to this question collected in the 2011 and 2012 Annual Survey of Registrants. Very small increases in the proportions of residents who were neutral about the GDC (+2%), who would speak highly *if asked* (+3%) and who would speak highly *without being asked* (+1%) can be seen between the 2011 and 2013 results. A decrease in the proportion of those who would be critical of the *GDC if asked* (-3%) and *without being asked* (-3%) can also be seen between 2011 and 2013. However, again the margin of error should be borne in mind (+/- 1.6% when interpreting these small changes).

A significantly larger proportion of dental hygienists and therapists reported that they would speak highly of the GDC *if asked* (35% and 38% respectively) and *without being asked* (9% and 13% respectively). However, dentists (21%), specialists (22%) and dental technicians (24%) were more likely to state that they would be critical of the GDC to others *if asked*.

The likelihood of speaking highly of the GDC *if asked* slowly decreases as the number of years registered increases, from 33% for those who had been registered for less than a year to 20% for those who were registered for 21 years and over. At the same time, the likelihood of being critical of the GDC *without being asked* increases from 5% for those who had been registered for less than a year to 23% for those who had been registered for 21 years and over.

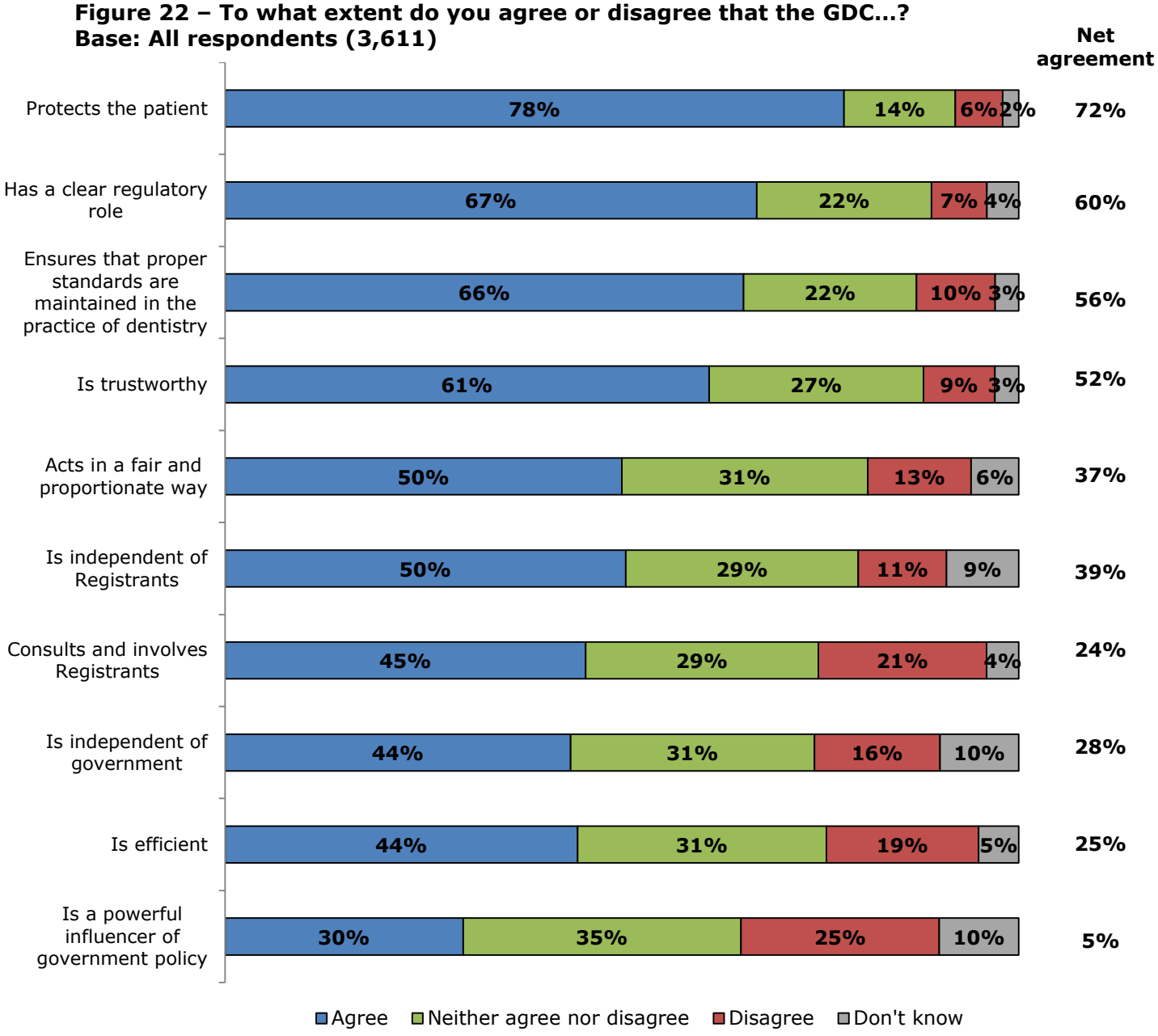
Male respondents appeared to be more critical of the GDC in comparison to female respondents. For example, 24% of male respondents would be critical of the *GDC if asked*, compared to just 10% of female respondents. Similarly, 27% of female respondents would speak highly of the GDC *if asked*, compared to 18% of male respondents.

Figure 21 – Thinking about all that you know about the GDC, which of the following statements would apply to you?
Base: All respondents – 2013 (3,611) / 2012 (4,160) / 2011 (2,827)



To further understand registrants' perspective on the GDC, survey respondents were asked to what extend they agreed or disagreed with a series of statements about the GDC. **Figure 22** below shows the overall levels of agreement and disagreement (the sum of the strongly agree/disagree and agree/disagree results), with the net agreement value presented on the right hand side (calculated by subtracting the disagree percentage from the agree percentage).

Figure 22 – To what extent do you agree or disagree that the GDC…?
Base: All respondents (3,611)



As can be seen, high level of agreement was recorded for the statement 'the GDC protects the patient' at 78%, with just 6% in disagreement. A larger proportion of dental therapists (89%) and hygienists (87%) were in agreement with this statement, particularly when compared with dental technicians (56%).

A further 67% were in agreement with the statement 'the GDC has a clear regulatory role', again with a small proportion in disagreement (7%) but almost a quarter indicating that they neither agreed nor disagreed (22%). Again, dental hygienists (79%) and

therapists (83%) were more likely to agree with this statement, and dental technicians were more likely to disagree (19%) or neither agree nor disagree (29%).

Almost the same proportion (66%) agreed with the statement 'the GDC ensures that proper standards are maintained in the practice of dentistry'. Subgroup analysis highlights similar patterns of results to previous statements, with larger proportions of dental hygienists (77%) and therapists (82%) in agreement when compared to dental technicians (39%) and specialists (48%).

Other statements shown in **Figure 23** show falling levels of agreement at the expense of either increased levels of disagreement, or perhaps more interestingly, increased levels of respondents who neither agreed nor disagreed. For example, the largest proportion of respondents stated that they neither agreed nor disagreed with the statement 'the GDC is a powerful influencer of government policy' at 35%, suggested by a significantly larger proportion of dental nurses (40%) when compared to other roles.

Table 6 below compares the 2013 results to this series of questions to those collected in 2011. As can be seen, for each statement the proportion of respondents who strongly agree has decreased and the proportion who either agree or neither agree or disagree has increased.

Table 6 – To what extent do you agree or disagree that the GDC…?
Base: 3,611 (2013) / 2,827 (2011)

To what extent do you agree or disagree that the GDC…?	Year	Strongly agree	Agree	Neither	Disagree	Strongly disagree	Don't know
Protects the patient	2013	29%	49%	14%	4%	2%	2%
	2011	38%	42%	12%	4%	2%	2%
	+/-	**-9%**	**+7%**	**+2%**	**-**	**-**	**-**
Has a clear regulatory role	2013	15%	52%	22%	5%	2%	4%
	2011	30%	42%	16%	6%	3%	3%
	+/-	**-15%**	**+10%**	**+6%**	**-1%**	**-1%**	**+1%**
Ensures that proper standards are maintained	2013	16%	50%	22%	7%	3%	3%
	2011	29%	42%	16%	8%	4%	2%
	+/-	**-13%**	**+8%**	**+6%**	**-1%**	**-1%**	**+1%**
Is trustworthy	2013	15%	46%	27%	6%	3%	3%
	2011	30%	36%	20%	6%	3%	4%
	+/-	**-15%**	**+10%**	**+7%**	**-**	**-**	**-1%**
Acts in a fair and proportionate way	2013	9%	41%	31%	8%	5%	6%
	2011	23%	36%	19%	11%	7%	4%
	+/-	**-14%**	**+5%**	**+12%**	**-3%**	**-2%**	**2%**
Is independent of Registrants	2013	12%	38%	29%	9%	2%	9%
	2011	19%	32%	27%	5%	2%	15%
	+/-	**-7%**	**+6%**	**+2%**	**+4%**	**-**	**-6%**
Consults and involves Registrants	2013	8%	37%	29%	14%	7%	4%
	2011	17%	27%	24%	17%	10%	5%
	+/-	**-9%**	**+10%**	**+5%**	**-3%**	**-3%**	**-1%**
Is independent of government	2013	9%	35%	31%	12%	4%	10%
	2011	13%	27%	29%	10%	6%	15%
	+/-	**-4%**	**+8%**	**+2%**	**+2%**	**-2%**	**-5%**
Is efficient	2013	10%	34%	31%	12%	7%	5%
	2011	19%	28%	23%	15%	9%	6%
	+/-	**-9%**	**+6%**	**+8%**	**-3%**	**-2%**	**-1%**
Is a powerful influencer of government policy	2013	5%	25%	35%	18%	7%	10%
	2011	12%	21%	30%	15%	9%	13%
	+/-	**-7%**	**+4%**	**+5%**	**+3%**	**-2%**	**-3%**

Qualitative findings

The reputation of the GDC was covered in both the focus groups and in depth interviews. In order to generate discussion, participants were shown the results to the previous question where survey respondents could agree or disagree with a series of statements about the GDC.

Fair and proportionate

A number of focus group and interview participants agreed with the 50% of survey respondents who said that the GDC acted in a fair and proportionate way. This view was generally expressed by those who were aware of GDC rulings and actions that they had read about either in the GDC Gazette or online, which they agreed with. A small number had direct and indirect experience of the GDC's rulings and used this to base their decision upon.

> *You read about the cases and outcomes in the magazine. It shows that they are fair in their rulings.*
>
> (Dental nurse, depth interview, Wales)

> *It's just what you see in the back of the Gazette. Some stuff does seem like they're being reasonable, they don't just strike people off for no reason.*
>
> (Dental technician, focus group, Nottingham)

> *I think that experience I had with the GDC was absolutely fabulous in that he no longer practises as a dentist.*
>
> (Dentist, focus group, Leeds)

However, at the same time a large proportion of participants did not agree that the GDC acted in a fair and proportionate way. A common reason behind this view was the perception that the GDC are often 'heavy handed' in the way that they regulate and treat registrants who have a concern raised about them, providing what they felt were harsh rulings such as suspensions and being struck off altogether. These participants saw this element of regulation as often disproportionate and encouraged a focus on deterrents.

It was explained that registrants were very fearful of being called before the GDC based on the perception that they would not be treated fairly or would be treated as guilty until proven innocent, thinking that the GDC favours the views of the public over that of the registrant. A smaller number of participants went as far as to state that they expected that if they were ever called before the GDC based on a concern raised by a patient that this would end their career.

> *Recent decisions made by them make me not so sure. It looks like it now needs to wield with a stick to do anything. I'm not sure some of the rulings are fair or proportionate. I know they're there to protect the patient, but they're now too far down the line of deterrents.*
>
> (Dentist, depth interview, Northern Ireland)

> *It's like the Spanish inquisition. Bulletins from the GDC are like a rogue's gallery as a deterrent to us – heads on spikes over Tower Bridge. It's as if they think we're all doing wrong all of the time, there's no trust from them.*
>
> (Dentist, focus group, Cardiff)

> *I think that the results are generally fair, but the methods are wrong. It's guilty until proven innocent rather than the other way around.*
>
> (Dentist, depth interview, Northern Ireland)

> *They're really heavy handed. I'd be scared to go to the GDC these days. If you get called in front of the GDC now you might as well kiss your career goodbye.*
>
> (Dentist, focus group, Leeds)

Other participants explained that the perceived the GDC's rulings as disproportionate as they felt that if a case brought in front of the GDC directly involved a patient the registrant involved would be very unlikely to come out of the hearing with their registration still intact, whereas if the case did not directly involve a patient, such as fraud or other finance related issues, then the registrant was more likely to get away with a less severe penalty.

> *If it's not about the patient you can get away with anything like major fraud. It's inconsistent. If you're prepared to defraud the NHS then you should forfeit your right to work in the profession completely.*
>
> (Clinical dental technician, depth interview, England)

In addition, a smaller number of participants, generally dentists, felt that the GDC disciplinary hearings were not fair as they perceived that those hearing the cases have an insufficient level of knowledge of dentistry and that cases can often be medically complicated. These participants explained that they felt a layperson may not understand the subtle or complex nature of some cases and were worried that they may be swayed by personality rather than the evidence.

> *Going up before the disciplinary committee, the people who are hearing these cases don't really have the knowledge or the expertise to understand the complexity of the case.*
>
> (Dentist, focus group, Glasgow)

When discussing the GDC as a fair and proportionate organisation, a small number of DCP participants indicated that the GDC was not always fair in the way that it dealt with DCPs in comparison to dentists. These participants held the perception that dentists would be more likely to be suspended had they been found to have done something wrong by the GDC, whereas they felt that DCPs, particularly dental nurses, would be more likely to be struck off.

> *If we did something wrong we'd be off. If a dentist does then it will be investigated further. There's still a difference between dentists and DCPs.*
>
> (Dental nurse, focus group, Nottingham)

> *They see nurses as a dime a dozen so they don't get listened to.*
>
> (Dental nurse, depth interview, Wales)

Efficient

The majority of qualitative research participants either stated that they did not feel the GDC was an efficient organisation or that they did not know enough about how the GDC operated and how it spent its money to judge.

A popular response provided by those who perceived the GDC to be inefficient was that their Annual Retention Fees were very high, particularly in comparison to other medical professions, which led them to believe that the cost of regulating dentistry was disproportionately high. As for the majority of participants the only interaction they had with the GDC was paying their fees, and that awareness of what their fees paid for was low, the level of the Annual Retention Fee was focused on by many respondents when discussing whether the GDC was efficient or not.

> *We pay much more to be regulated than other health care professions who pose a greater risk to patients.*

(Hygienist, depth interview, Scotland)

They're efficient at taking my money. If you don't get into trouble they are very distant so you don't really know.

(Dentist, depth interview, England)

A smaller proportion of participants had more awareness of the GDC's processes including Fitness to Practise hearings and therefore had some understanding of the time taken and the costs included. These respondents used this knowledge when coming to the decision that the GDC was not efficient, believing the processes to take a very long time and to cost a lot of money.

The process if a concern is raised is very long winded and can take years, perhaps that could be speeded up.

(Dentist, depth interview, England)

A friend of mine was brought before the GDC because when she first registered in 2008 she had ticked the wrong box and something showed up on her CRB check. There were about three or four court dates…for them to suspend her for a month. It was the biggest waste of money, the biggest waste of time.

(Dental nurse, focus group, Reading)

A further reason suggested for holding the view that the GDC was not efficient was the awareness that the GDC was based in central London offices. Some participants also believed that the GDC were employing expensive external consultants which they are ultimately paying for via their fees. It was felt that moving out of central London would increase efficiency as it would reduce running costs, including both the building cost and staff costs, and the cost of Fitness to Practise proceedings significantly.

Why do they need such expensive offices in Wimpole Street? They could be based in Merthyr or somewhere. It's all paper based so they could operate anywhere.

(Dentist, focus group, Cardiff)

There is a lot of paperwork, and they're based in central London with lots of staff, so perhaps they could be more efficient.

(Dental nurse, depth interview, Wales)

Why are they paying people externally? They could have their own legal team running constantly instead of so many people gaining…that's what we're paying for – their daily rates

(Dentist, focus group, Glasgow)

Participants who indicated that they could not judge whether the GDC were efficient or not explained that they did not know enough about the GDC, how it behaved or how it spent the money it received to be able to form an opinion.

I don't really know enough about them to be able to say if it's efficient or not. I'd probably say they shouldn't be spending money telling us they're efficient – they should concentrate on getting on with the job.

(Dentist, depth interview, Northern Ireland)

I have no idea where the money we pay goes, so can't really say whether they are efficient or not.

(Dentist, depth interview, England)

Understanding that the GDC protects the patient, but what about support for the professional?

The statement 'the GDC protects the patient' incited significant discussion amongst focus group and in depth interview participants. Almost all participants agreed that the GDC protected the patient and understood that this was its primary role.

> *They're meant to look after patients and that's exactly what they do.*
>
> (Dentist, depth interview, Wales)

> *I do think there is a massive need for patients to be protected because for every wonderful dentist there is, there is an absolute horror story.*
>
> (Dental nurse, focus group, Leeds)

However, almost all of these participants went on to state that whilst the GDC was effective at protecting the patient, they felt that, whilst they understood it was not its role, the GDC did very little protect the dental professional in terms of advice and support. It was highlighted by a number of participants that their strong focus on protecting the patient made dental professionals feel as though their views and opinions were not as valid in comparison and that the GDC would always take the word of the patient over that of the dental professional. It was also suggested that the perception of the GDC as an organisation only interested in protecting the patient and not the dental professional has led to many registrants being afraid of the GDC.

> *The only time the GDC will act on anything is if the patient is at risk. Otherwise they're not interested.*
>
> (Dental technician, focus group, Nottingham)

> *I agree that they protect the patient as that's its primary aim. But maybe they forget that the professional is a person too. They come across a bit like the dental police when most people haven't done anything wrong. It's very them and us, patients and professionals.*
>
> (Dentist, depth interview, England)

> *It's something to be feared really, almost.*
>
> (Dental nurse, focus group, Leeds)

When asked what information or evidence they use to base their opinions of the GDC on, the most common responses include word of mouth from and interaction with other dental professionals and colleagues, the GDC website and the GDC Gazette. The majority of participants admitted that they had had little or no experience of individual contact from or direct dealings with the GDC, and therefore had to base their opinions on mass communication channels.

> *I read things on the website, look at council meeting minutes.*
>
> (Hygienist, depth interview, Scotland)

> *A lot of why you think what you do about them is word of mouth. People talk and you try and keep informed when you can.*
>
> (Dentist, depth interview, Northern Ireland)

> *I read the journals and papers and have worked with professionals who have sometimes got into trouble with the GDC. From that I think they're doing a good job.*
>
> (Dentist, depth interview, Wales)

Focus group and in depth interview participants were asked why they thought that the 2013 survey results showed an increase in the proportion of residents who neither

agreed nor disagreed with the majority of statements about the GDC and a decrease in the proportion who strongly agreed. The general consensus from participants was that, as GDC registrants, they have very little interaction with the GDC apart from paying their Annual Retention Fee and that they are generally glad of this as, in their opinion, interaction with the GDC could mean that they had done something wrong. This suggests a contradiction of opinions, with some registrants wanting to hear more from the GDC, but at the same time indicating that they are happy not to have any interaction with them.

Therefore, participants felt that these low levels of interaction with the GDC, which they felt would be the same for the majority of registrants, may have led to registrants not having sufficient information to agree or disagree with statements about the GDC's reputation.

> *There's not a great deal of information that comes out from them. If the information isn't out there then how can you form an opinion on it?*
>
> (Dental therapist, focus group, Nottingham)

> *They don't have much interaction with us. You don't hear from them at all.*
>
> (Dental nurse, focus group, Reading)

> *It's easy to be apathetic about this kind of thing because the whole GDC thing doesn't really affect me.*
>
> (Dental technician, focus group, Glasgow)

2.3.4 In touch with the views of dentists, DCPs, and patients/the public

Survey respondents were asked how in touch they thought the GDC was with the views of dentists, DCPs, patients and the public. **Figure 23** shows the overall response to this question. A greater proportion of respondents felt that the GDC was in touch with the views of dentists (a total of 64%) than of DCPs (a total of 48%). Whilst 19% of respondents felt that the GDC was not very in touch with the views of dentists, 28% thought they were not very in touch with the views of DCPs.

Subgroup analysis shows that a greater proportion of DCPs felt that the GDC was in touch with the views of dentists, particularly dental nurses (74%) and hygienists (73%) when compared with dentists and specialists, where a much smaller proportion indicated that they thought the GDC was in touch with them (49% and 45% respectively).

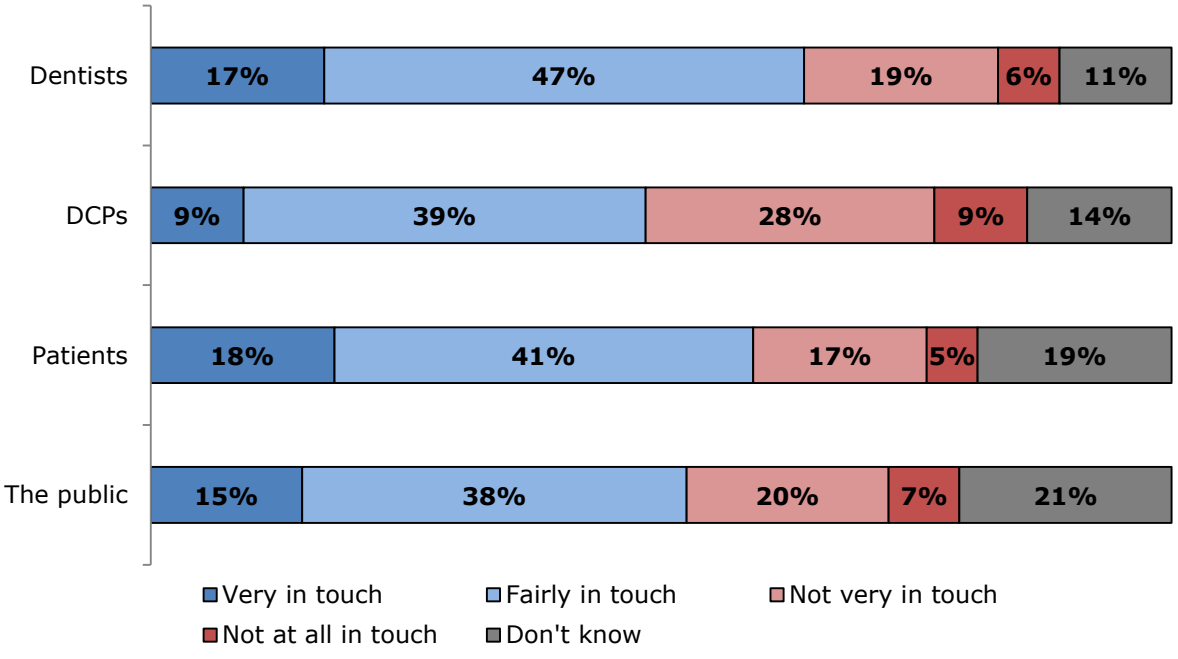
The sample also shows that a greater proportion of DCPs also felt that the GDC was in touch with their own views, particularly dental hygienists (70%), therapists (70%) and nurses (54%). Dental technicians, however, were far less likely to agree that the GDC was in touch with DCPs at just 29%, along with dentists (39%) and specialists (35%) who were also more likely to state that the GDC was not in touch with DCPs.

Female respondents appear to feel that the GDC is more in touch with both dentists and DCPs at 69% and 52% respectively, compared to 51% and 37% for male respondents.

When looking at how in touch respondents felt the GDC was with patients and the public, the majority answered that GDC was in some way in touch with their views (59% patients, 53% the public). However, an increase in the proportion of respondents indicating that they do not know can be seen for both patients (19%) and the public (21%).

As witnessed in 2012, it is interesting to note that respondents think that the GDC is more in touch with the views of patients (59%) and the public (53%) than DCPs (48%).

Figure 23 – How in touch would you say the GDC is with the views of each of the following?
Base: All respondents (3,611)



This question has now been asked for the past three years, allowing for results to be tracked and comparisons to be made. **Table 7** below presents the figures from each year and the difference in results from 2011 to 2013. It is encouraging to see that there has been an increase in the proportion of respondents who felt that the GDC was in touch with both dentists (+4%), DCPs (+5%) and the public (+3%).

Proportions of those indicating that the GDC was not in touch has decreased for all audiences, but the proportion of those indicating that they do now know has increased.

Table 7 – Is the GDC in touch with dentists, DCPs, patients and the public – 2011, 2012 and 2013 results
Base: All respondents – 2013 (3,611) / 2012 (4,160) / 2011 (2,827)

	In touch				Not in touch				Don't know			
Group	2013	2012	2011	+/-	2013	2012	2011	+/-	2013	2012	2011	+/-
Dentists	64%	60%	60%	+4%	25%	26%	31%	-6%	11%	14%	8%	+3%
DCPs	48%	41%	43%	+5%	37%	41%	47%	-10%	14%	18%	10%	+4%
Patients	59%	56%	60%	-1%	22%	22%	28%	-6%	19%	23%	13%	+6%
The public	53%	49%	50%	+3%	27%	25%	35%	-8%	21%	25%	15%	+6%

2.4 The Annual Retention Fee

2.4.1 Current Annual Retention Fee levels

Survey respondents were asked to indicate whether they thought that the current level of the Annual Retention Fee for dentists and DCPs was about right, too high or too low. Looking at the fee which dentists currently pay (£576), **Figure 24** below shows that over two in five respondents felt that the fee was too high (44%), closely followed by 39% who indicated that it was about right. Just 4% said that the level of fee for dentists was too low.

In comparison to previous years, the 2013 results show a small decrease in the proportion of respondents stating that the level of fee for dentists was too high from 47% in 2011 and 2012 to 44% in 2013 (-3%). The proportion of respondents who indicated that the level of fee for dentists was about right has slightly increased from 37% in 2012 to 39% in 2013 (+2%), however the proportion who felt that the fee was too low has remained constant at 4%. These changes in percentage are only just outside the margin of error (+/- 1.6%) and therefore should not be given too much emphasis.

Figure 24 – Would you say that the level of fee for dentists is…?
Base: All respondents – 2013 (3,611) / 2012 (4,160) / 2011 (2,827)

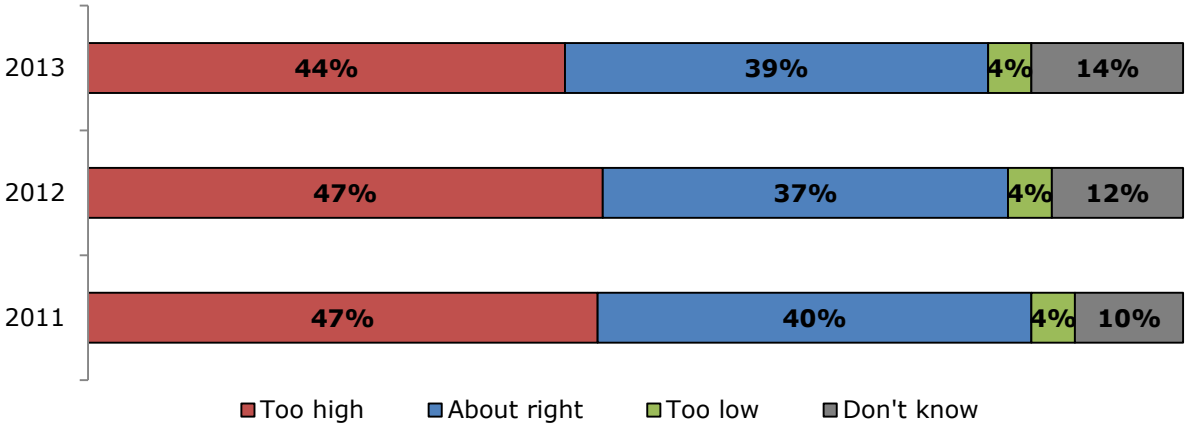


Table 8 overleaf shows that almost four in five dentists (78%) indicated that the level of fee for dentists was too high, and just 20% that it was about right. A similar result can be seen for respondents who indicated that they were specialists, with 72% indicating that the fee level was too high and 23% that it was about right.

When comparing these results to the previous year's survey, we can see a small pattern of reduction in the proportion of dentists who felt that the fee was too high of 7% (85% in 2011, 79% in 2012, 78% in 2013), and a slight increase in dentists indicating that the fee was about right of 6% (14% in 2011, 19% in 2012, 20% in 2013).

DCP respondents, however, were more likely to state that the level of fee for dentists was about right, as shown in **Table 8**. The majority of dental nurses (52%), hygienists (54%) and therapists (52%) all stated that the level of fee for dentists was about right.

A larger proportion of those of Asian/Asian British ethnicity indicated that the fee level for dentists was too high at 71% (compared to 44% overall), as did a larger proportion of male respondents at 66% compared to female respondents at 36%.

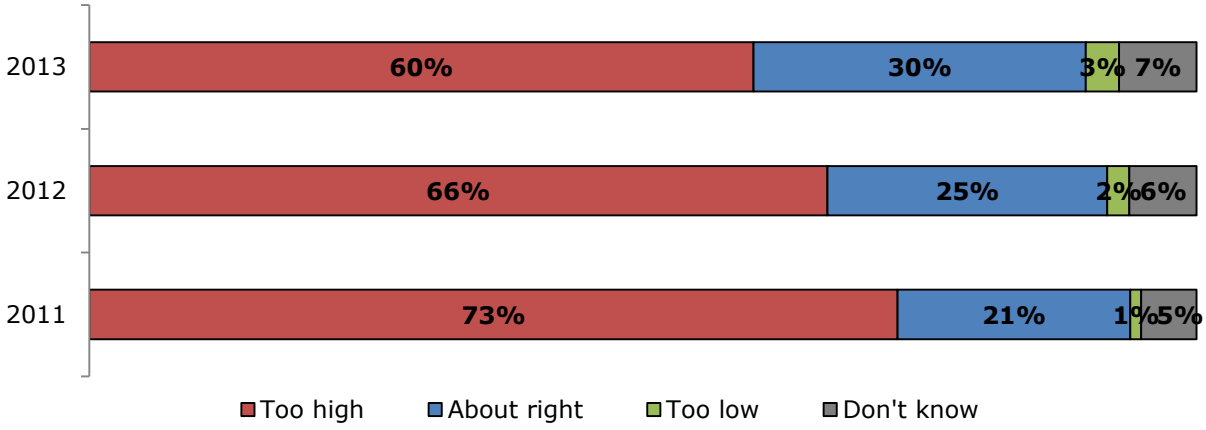
Table 8 – Opinion of the ARF level for dentists by dental professional group

Group	Too high	About right	Too low	Don't know
Dentist	78%	20%	0%	2%
Specialist	72%	23%	-	5%
Dental therapist	31%	52%	5%	12%
Dental nurse	21%	52%	6%	20%
Dental hygienist	19%	54%	5%	22%

Looking at the fee which DCPs currently pay (£120), **Figure 25** below shows that the majority of respondents felt that the fee was too high (60%), with a further 30% who indicated that it was about right. Just 3% said that the level of fee for DCPs was too low.

In comparison to previous years, the 2013 results show a constant decrease in the proportion of respondents stating that the level of fee for DCPs was too high from 73% in 2011 to 60% in 2013 (-13%). The proportion of respondents who indicated that the level of fee for DCPs was about right has also steadily increased from 21% in 2012 to 30% in 2013 (+9%).

Figure 25 – Would you say that the level of fee for DCPs is…?
Base: All respondents – 2013 (3,611) / 2012 (4,160) / 2011 (2,827)



When looking at individual dental professional groups shown in **Table 9** overleaf, the sample highlights significant differences. Within the DCP groups, a much larger proportion of dental nurses indicated that the fee is too high for DCPs at 86% followed by 68% of dental technicians. However, the majority of dental therapists and hygienists stated that the fee level was about right at 65% and 64% respectively. Just over two in five dentists said that they thought the fee level for DCPs was about right (43%), but a significant proportion also stated that the DCP fee level was too high (34%).

Again, when comparing these results to the results from 2011 and 2012, we can see a constant reduction in the proportion of DCPs who indicated that the fee was too high of 6% (83% in 2011, 79% in 2012, 77% in 2013). Conversely, a steady increase in DCPs indicating that the fee was about right of 6% can also be seen (15% in 2011, 19% in 2012, 21% in 2013).

A larger proportion of those of Asian/Asian British ethnicity indicated that the level was about right at 43% (compared to 30% overall) and a larger proportion of female respondents indicated that the level was too high at 66% compared to male respondents at 45%.

Table 9 – Opinion of the ARF level for DCPs by dental professional group

Group	Too high	About right	Too low	Don't know
Dental nurse	86%	13%	0%	1%
Dental technician	68%	28%	0%	4%
Dental therapist	35%	65%	-	1%
Dental hygienist	34%	64%	-	2%
Dentist	34%	43%	8%	15%

Qualitative findings

The GDC is continuing its review of the principles on which the Annual Retention Fee is based and, therefore, wished to explore registrant views on the subject during the in depth telephone interviews. The themes expressed were generally the same as those seen in 2012 – that the dentist fee was generally fair, but that having one level fee for all six DCP groups was not, particularly for dental nurses.

It was highlighted by all dental professional groups, both dentist and DCP, that the fee level for DCPs of £120 per year was unfair as the same amount was paid by all six DCP groups despite quite large differences in their earning ability. The example of the typical difference in salary between dental nurses and hygienists was provided by many interview participants in a wide variety of roles. Dental nurses in particular felt that the fee they paid was too high based on their earnings, and also on the fact that many dental nurses do not work full time hours. Sympathy was expressed for dental nurses by those in other roles for the same reasons. Only a handful of dental nurses felt that their fee level was about right, but all of these indicated that their employer paid their fees on their behalf.

> *They said they consulted with a group of nurses, therapists and hygienists and what came out of it was that dental nurses should pay the same retention fee as the hygienists, who earn at least twice as much as we do.*
>
> (Dental nurse, focus group, Reading)

> *It's unfair for dental nurses as a lot only work a couple of days a week.*
>
> (Dentist, depth interview, England)

In comparison, around half of dentists who participated in the focus groups or in depth interviews who paid £576 per year indicated that the fee level was fair based on the amount they can earn and the need for effective regulation of dentists. This contrasts to the results of the survey, where most dentists indicated the fee was too high.

> *If that's what they need to collect to regulate then that's what they have to charge. Someone has worked it out.*
>
> (Dentist, depth interview, Northern Ireland)

> *Dentists' fees are set at the level they need to be.*
>
> (Dentist, depth interview, England)

A similar proportion of dentists, however, explained that they thought their fee level was too high. A number of participants stated that not all dentists earned high salaries, so the GDC's fee did have an impact on their finances. It was highlighted that paying the fee had a bigger impact on dentists due to the time that it was collected just before Christmas in one lump sum rather than in staged payments. As also seen in 2012, a smaller numbers of dentists felt their fee was too high, particularly for those who have

recently qualified. They explained that newly qualified dentists have a lot of debt and find it difficult to begin paying out for their registration fees straight away. It was suggested that paying in instalments would help these dentists in particular.

> *For dentists, they very kindly let you pay the whole fee at once, basically at Christmas. They won't let you pay in instalments, it's all at once at Christmas…We're not all rolling in money at an expensive time of the year.*
>
> (Dentist, focus group, Leeds)

> *Everything is too high, including GDC's fees. As a recent graduate I still have £40,000 of debt. It always comes at a bad time too and there's no way of spreading the cost over the year. But I have to pay or else I'm illegal. It's especially hard for new graduates. I've had to move back in with my parents to be able to afford to practise.*
>
> (Dentist, depth interview, England)

The reason these views of the Annual Retention Fee for both dentists and DCPs appear to be held is from knowledge of what other medical regulatory bodies such as the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) charge professionals. They were aware that these bodies charged less for what they understood to be a similar role, often for medical professional roles which involved a greater interaction directly with patients and therefore a greater level of risk to the public. Dentists typically compared their level of fee to those paid by doctors to the GMC and dental nurses compared their level of fee to those paid by nurses and midwives to the NMC. By comparison, therefore, they felt that the fees they paid were disproportionally high.

> *It's not proportionate when you compare it to other health professions. Registered nurses only pay something like £68 a year but dental nurses pose very little threat to patient safety. It's the same for dental technicians.*
>
> (Hygienist, depth interview, Scotland)

> *I know that it costs less to be registered as a midwife than it does to be a dental nurse. That doesn't make sense does it? It's not proportionate.*
>
> (Dental nurse, depth interview, England)

> *I think they're vastly overpriced. I'm registered with both the GDC and the GMC and it costs me £200 more to be registered with the GDC which I think is hard to justify for the work they do. I also pay more to be on a specialist list but I don't know what I get for that.*
>
> (Dentist, depth interview, Wales)

It was widely suggested by interview participants from all dental professional groups that the Annual Retention Fee for DCPs should be set based on the salary or potential earnings of the individual, or based on the professional group which the individual is registered as and how much of a clinical role it is, in order to bring fairness to the amount DCPs are expected to pay. It was also suggested that the ARF should take into account those who did not work full time hours and should be charged on a proportional basis. The same feedback was seen in the 2012 qualitative research.

> *It's too high. It should be income based. A full time hygienist earns way more than a nurse. Either up the hygienist fee or lower the nurses' fee.*
>
> (Dental nurse, depth interview, England)

> *We pay less than dentists, but I think anyone in a clinical role should pay a bit more like therapists and hygienists.*
>
> (Dental technician, depth interview, Scotland)

It's not pro-rata either…so if you're working only two days you have to pay exactly the same as everybody else. It needs to be taken into account.

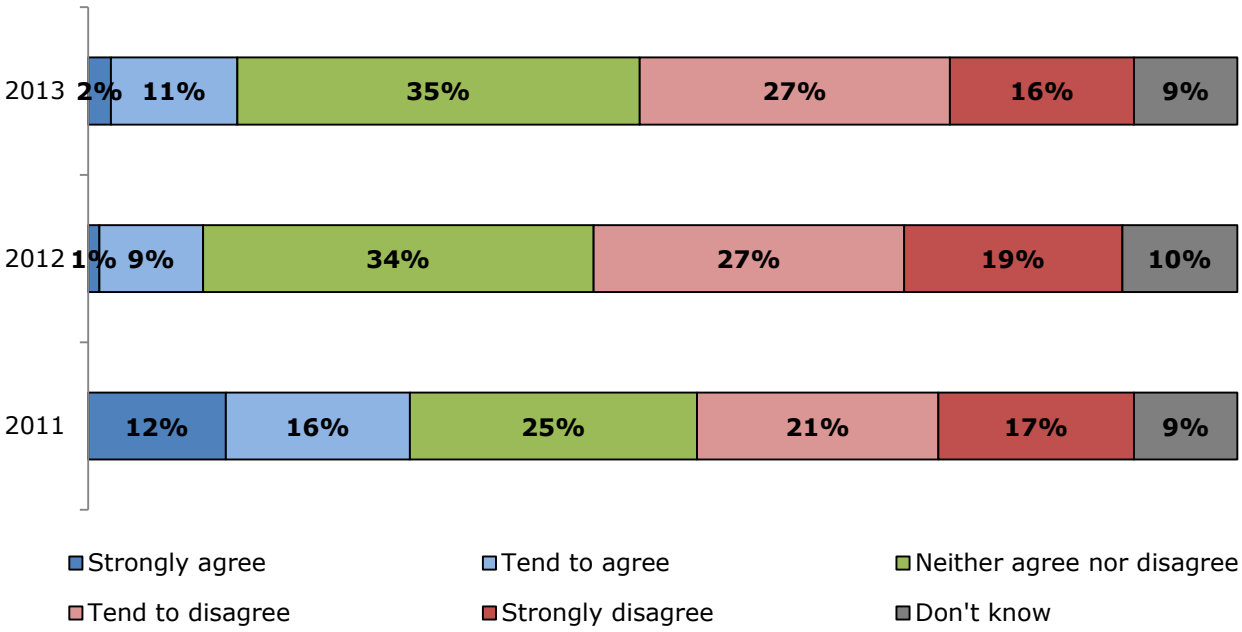
(Dental nurse, focus group, Reading)

2.4.2 The cost-effectiveness of the GDC

Following on from questions relating to the Annual Retention Fee, survey respondents were asked to what extent they agreed or disagreed that the GDC is cost-effective. As a question about cost-effectiveness directly follows questions about the ARF, this may have had some impact on the responses provided. As shown in **Figure 26**, the majority of respondents disagreed that the GDC was cost-effective with a total of 43% (27% tended to disagreed, 16% strongly disagreed), followed by a further 35% who indicated that they neither agreed nor disagreed. Just one in eight agreed that the GDC was cost-effective with a total of 13% (11% tended to agree, 2% strongly agreed).

In comparison to previous years, a small increase of 3% in those who agreed can be seen between 2012 (10%) and 2013 (13%), as can an equal decrease of 3% in those who disagreed (46% in 2012, 43% in 2013). However, the results are significantly different to those recorded in 2011, where a total of 28% agreed that the GDC was cost-effective.

Figure 26 – To what extent do you agree or disagree that the GDC is cost-effective?
Base: All respondents – 2013 (3,611) / 2012 (4,160) / 2011 (2,827)



Dentists (49%), specialists (63%) and dental technicians (51%) were more inclined to disagree (compared to 43% overall), particularly when compared to dental hygienists (20%) and therapists (27%).

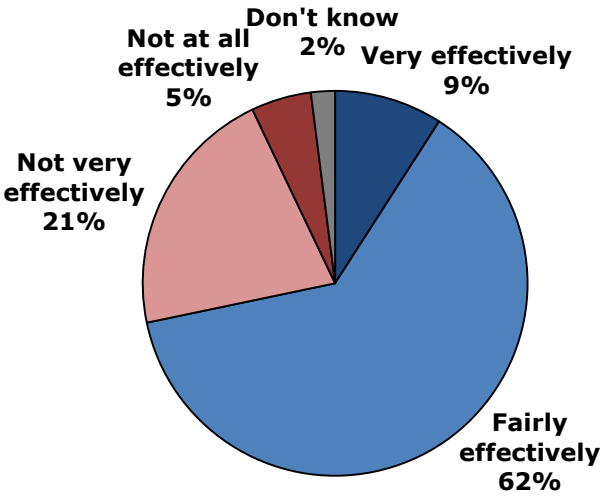
In terms of country, a larger proportion of respondents working in Northern Ireland said that they neither agreed nor disagreed that the GDC was cost effective at 46% (compared to 35% overall). Male respondents were more likely to disagree at 54% compared to female respondents at 38%, whereas female respondents were more likely to neither agree nor disagree at 38%, compared to male respondents at 28%.

2.5 Communication

2.5.1 Effective communication

All respondents were asked to indicate how effectively they felt the GDC communicated with them. Seven in ten survey respondents (71%) felt that the GDC communicated with them effectively, with 62% indicating that they felt the GDC communicated fairly effectively and 9% very effectively. However, a quarter (26%) felt the GDC did not communicate effectively with them.

Figure 27 – In general, how effectively, if at all, do you think the GDC communicates with you?
Base: All respondents (3,611)



Subgroup analysis highlights that a larger proportion of dental hygienists felt that the GDC communicated with them effectively (16% very effectively, 70% fairly effectively), whereas dental technicians were more likely to suggest that the GDC did not communicate with them effectively (33% not very effectively, 9% not effectively at all).

The sample also highlights that a slightly larger proportion of respondents who lived in Wales felt that the GDC communicated with them effectively at 78% (compared to 71% overall).

Table 10 shows this year's results alongside those collected in 2011 and 2012. It is positive to note that since 2011 there has been a slightly increase in the proportion of respondents who felt that the GDC communicated fairly effectively (+5%), with slight decreases seen in the proportion of respondents who did not think the GDC communicated effectively.

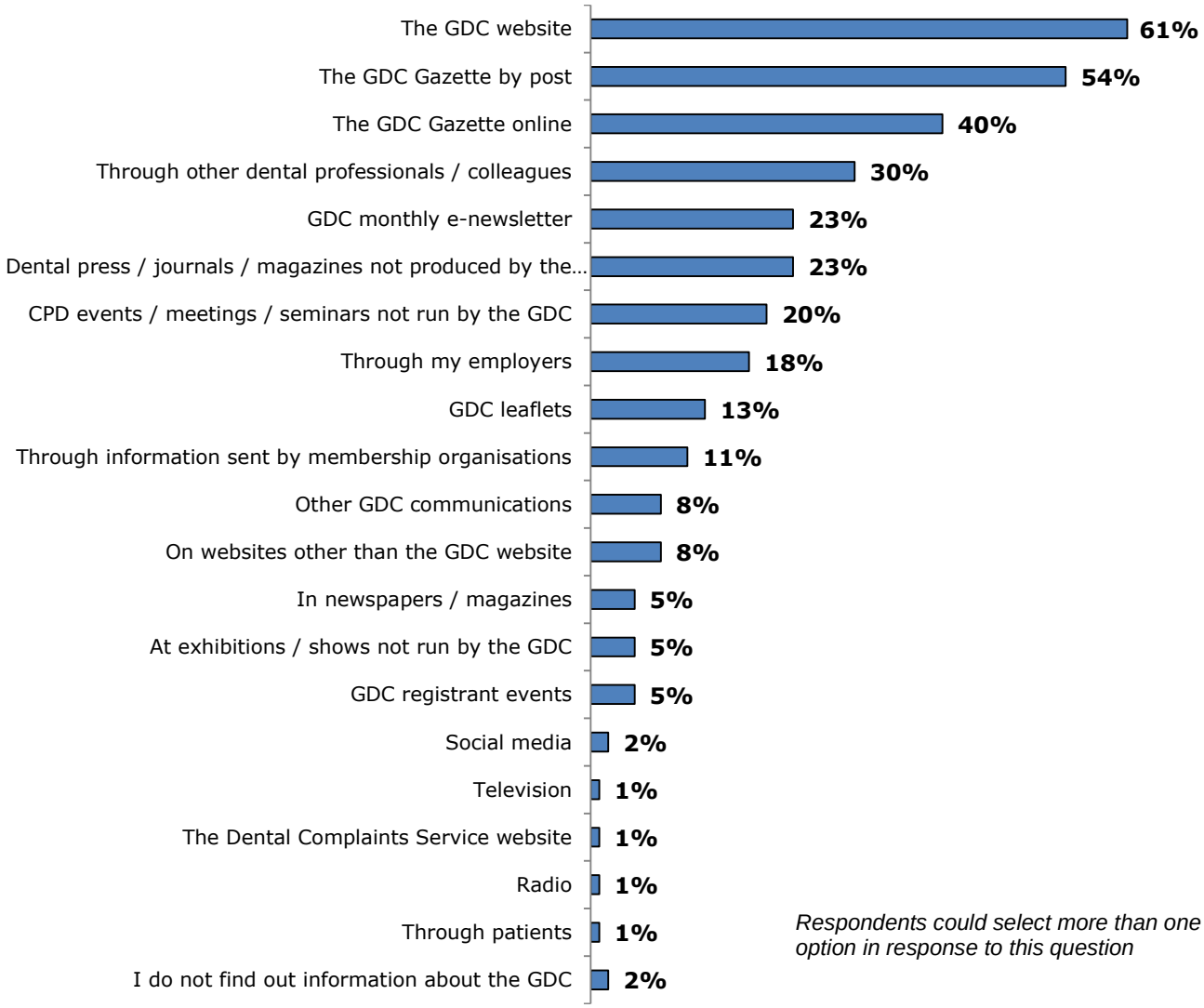
Table 10 – Effectiveness of communication – 2011, 2012 and 2013 results
Base: All respondents – 2013 (3,611) / 2012 (4,160) / 2011 (2,827)

Level of effectiveness	2013	2012	2011	Overall Difference
Very effectively	9%	9%	10%	-1%
Fairly effectively	62%	61%	57%	+5%
Not very effectively	21%	22%	24%	-3%
Not effectively at all	5%	5%	7%	-2%
Don't know	2%	3%	2%	-

2.5.2 Communication channels

On the topic of communication, respondents were also asked how they find out information about the GDC, and were able to select more than one option within the survey. The most common way of finding out information was via the GDC website, suggested by three in five respondents (61%). This was followed by a further 54% who suggested the GDC Gazette by post, a publication which has not been provided to registrants for approximately a year. This percentage may therefore be a lagging indicator, highlighting that not all registrants are aware that the GDC Gazette by post is no longer available. The complete response to this question can be seen in **Figure 28**.

Figure 28 – How do you find out information about the GDC?
Base: All respondents (3,611)



Finding out information about the GDC via the GDC website was more popular with dental hygienists (71%), therapists (72%) and specialists (70%) compared to other dental professional groups.

The Gazette by post was suggested by a larger proportion of dentists (60%), specialists (63%) and dental therapists (67%), and was also more popular with those who had been registered with the GDC for a longer period of time, as seen last year. For example, the GDC Gazette by post was suggested by just 15% of those who had been registered for less than a year, but was suggested by 67% of those who had been registered for 21 years and over.

The GDC Gazette online was suggested by a larger proportion of dental hygienists (50%). In terms of location, a larger proportion of those who indicated that they lived in Wales suggested both the GDC Gazette online (44%) and the monthly e-newsletter (26%), particularly when compared to respondents who lived in Northern Ireland where smaller proportions suggested these two communication channels (33% and 14% respectively).

Younger respondents tended to find out information about the GDC through other dental professionals and colleagues, particularly those aged 16 to 30 at 37% (compared to 30% overall).

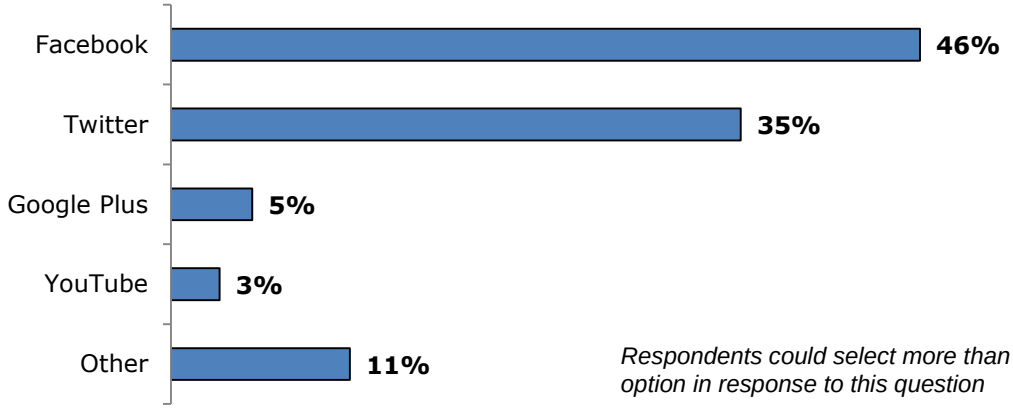
When comparing these results to previous years, significant differences can be seen when looking at online sources of information against print. As shown in **Table 11**, the GDC website (+5%), the GDC Gazette online (+29%) and the GDC monthly e-newsletter (+23%) have all experienced increases in the percentages of respondents stating that they use these communication channels to find out information about the GDC. By contrast, the GDC Gazette by post has fallen from 77% in 2012 to 54% in 2013 (-23%). It is also interesting to note that an increase in respondents finding out information about the GDC through their employers has increased from less than 1% in 2011 to 18% in 2013 (+18%).

Table 11 – How do you find out information about the GDC? By year
Base: All respondents – 2013 (3,611) / 2012 (4,160) / 2011 (2,827)

Communication channel	2013	2012	2011	Overall Difference
The GDC website	61%	52%	56%	+5%
The GDC Gazette by post	54%	77%	70%	-16%
The GDC Gazette online	40%	24%	11%	+29%
GDC monthly e-newsletter	23%	16%	-	+23%
Through my employers	18%	14%	0%	+18%

Those who had suggested they found out information about the GDC via social media (2%) were additionally asked to specify which social media they would prefer the GDC to use to communicate with them. Respondents were able to select more than one option within the survey. Facebook was the most common response, suggested by almost half of these respondents (46%), followed by a further 35% who suggested Twitter. 'Other' responses related to either 'email' or respondents explaining that they did not think social media was an appropriate communication tool for the GDC.

Figure 29 – Which one of the following social media would you prefer the General Dental Council to use to communicate with you?
Base: Respondents who mentioned social media (74)



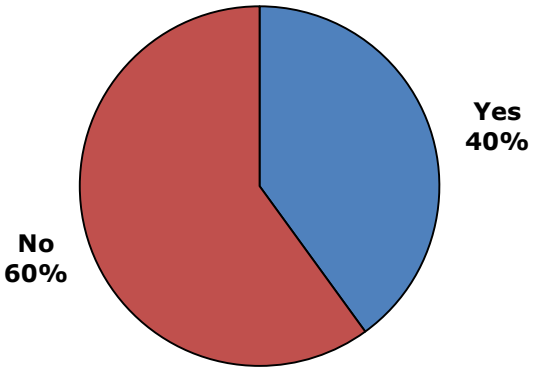
2.6 Written CPD Plans

The GDC is currently consulting with registrants on proposals for new Continuing Professional Development (CPD) requirements that will contribute to the continuing assurance of practice of all those on the GDC's register. These include a proposal that in the future a written plan of intended CPD is required. The GDC would expect all registrants to hold and maintain a plan of their intended CPD based on their individual reflection, and reflection with others, about their CPD needs in the context of their scope of practice and the GDC's Standards.

To explore this issue further, all survey respondents were asked whether they currently had a written plan of the CPD that they intend to carry out in the next year (a new question for the 2013 Annual Survey). As seen below in **Figure 30**, the majority of survey respondents indicated that they did not have a written plan of CPD (60%).

Analysis of key subgroups shows that dentists and specialists were most likely to indicate that they did have a written plan of CPD at 42% and 50% respectively, particularly when compared to dental technicians at 29%. In terms of ethnicity, a larger proportion of Asian or Asian British respondents also indicated that they had a written plan of CPD at 52%.

Figure 30 – Do you have a written plan of the CPD that you intend to carry out in the next year?
Base: All respondents (3,611)



Qualitative findings

Most focus group participants were surprised by the level of survey respondents who said that they had a written CPD plan as just one focus group participant indicated that they currently had one. It was suggested that this large percentage of survey respondents may include those who have a personal development plan or who have set a development plan as part of an appraisal process which they may perceive to be a written plan of their CPD.

> *I'd say the majority of people would say no.*
>
> (Dental nurse, focus group, Leeds)

> *Personal development plans…they're normally attached to appraisals…it's a plan of what you want to do, where you see yourself in a year.*
>
> (Dental nurse, focus group, Reading)

The participant who had a written CPD plan worked in an NHS hospital setting and said that they felt formal CPD plans would be more common place as part of their ongoing training. It was also suggested that those working in private and smaller practices would be less likely to have a written CPD plan as they would be 'too busy' to be burdened by further paperwork.

> *CPD plans and regular review is more firmly embedded in the hospital setting than it is in private practice.*
>
> (Dentist, focus group, Cardiff)

> *Everybody is too busy working to have something like that.*
>
> (Dental nurse, focus group, Glasgow)

The proposal for the requirement to have a written CPD plan was discussed within the focus groups and it was almost universally agreed that it would be difficult for dental professionals to have a written plan. Various practical reasons were suggested for this. Firstly, it was suggested that CPD would be difficult to schedule so far in advance, with courses generally being advertising only a few months in advance.

> *You don't know what CPD is coming up that far in advance. There aren't always planned courses. You're lucky to find out about some.*
>
> (Dental hygienist, focus group, Nottingham)

Secondly, participants also suggested that their own changing circumstances would make a written CPD plan difficult to create and stick to. For example, they may no longer be able to attend a certain course, or may no longer wish to focus on the topic of the course they have already booked on to. A number of participants highlighted course cancellation charges and how these would also make a written CPD plan impractical.

> *If I set it out and said 'right here's my plan' that would be a massive drawback because then I probably wouldn't be able to get on the courses to actually fulfil that.*
>
> (Dentist, focus group, Leeds)

> *Its absolute nonsense – why would you plan the CPD you might not be able to do*
> (Dentist, focus group, Glasgow)

It was also suggested by a number of participants that accessing CPD within their place of work would also make a written plan difficult to create and adhere to, as it can be difficult to book the time off for CPD and they cannot predict problems arising such as funding, staff shortages, illness and holidays, which would result in their planned CPD being refused.

> *You can't go off and say 'right I'm going to do this' because it won't be funded…you just do what comes in.*
>
> (Dental nurse, focus group, Reading)

> *People wouldn't stick to it because you might say 'oh, I'm going to go on that course in ten months' time' but then when ten months' time comes you've booked a holiday or you're ill, or you've changed your job, or you can't get the time off.*
>
> (Dental technician, focus group, Leeds)

Taking these practicalities into consideration, it was generally felt that written CPD plans would be created by registrants but that they would be difficult to adhere to and would,

therefore, become a work of fiction. This led participants to see the idea of a written CPD plan as a 'paperwork' or 'box-ticking' exercise.

> *If you make it that they've got to have a written plan they're going to end up making stuff up because you feel you have to.*
>
> (Dental nurse, focus group, Reading)

A number of focus group participants also questioned the reason for having a written plan of CPD, explaining that they struggled to understand why it would be required and what benefits it would have. It was also questioned on a number of occasions by participants if and how the plan would be checked and verified, and if this was not the case then why it was necessary.

> *I don't see the purpose. Why would we need to tell them what we're planning to do if by the end of the year we've done it? I don't see what the GDC would get out of it at all.*
>
> (Dental technician, focus group, Nottingham)

A small number of participants also questioned the purpose of having a written plan of CPD, but also found the idea of being required to create one as untrusting of dental professionals and patronising. They explained that they already understood CPD requirements and ensured that they completed necessary levels of CPD each year and that they would not appreciate further reminders and 'hand-holding' to do this.

> *It's patronising to us…we've got some intelligence, we can work out what we need to do.*
>
> (Dentist, focus group, Leeds)

> *You don't need me to tell you in advance that I'm going to do it because I'm already telling you that I've done it.*
>
> (Dentist, focus group, Leeds)

Whilst the majority of participants were not in favour of written CPD plans and found it hard to see the benefits that they could bring, a smaller number of participants, when asked, indicated that they could see some benefit to having a written CPD plan. This focused on encouraging registrants to take control of their own development, particularly those who they felt may be less organised and not focused on their own development. It was also suggested that a mandatory written CPD plan could be a good idea for those newer to the profession who are not accustomed to CPD procedures.

> *In an ideal world it would be very useful because, as will everyone else, I just do stuff when it comes up…I try and keep an eye on my courses and make sure I've done that. I guess it will give you some structure but it's unworkable.*
>
> (Dentist, focus group, Leeds)

> *It could work as a basic guide, but it couldn't be set in stone.*
>
> (Dental nurse, focus group, Nottingham)

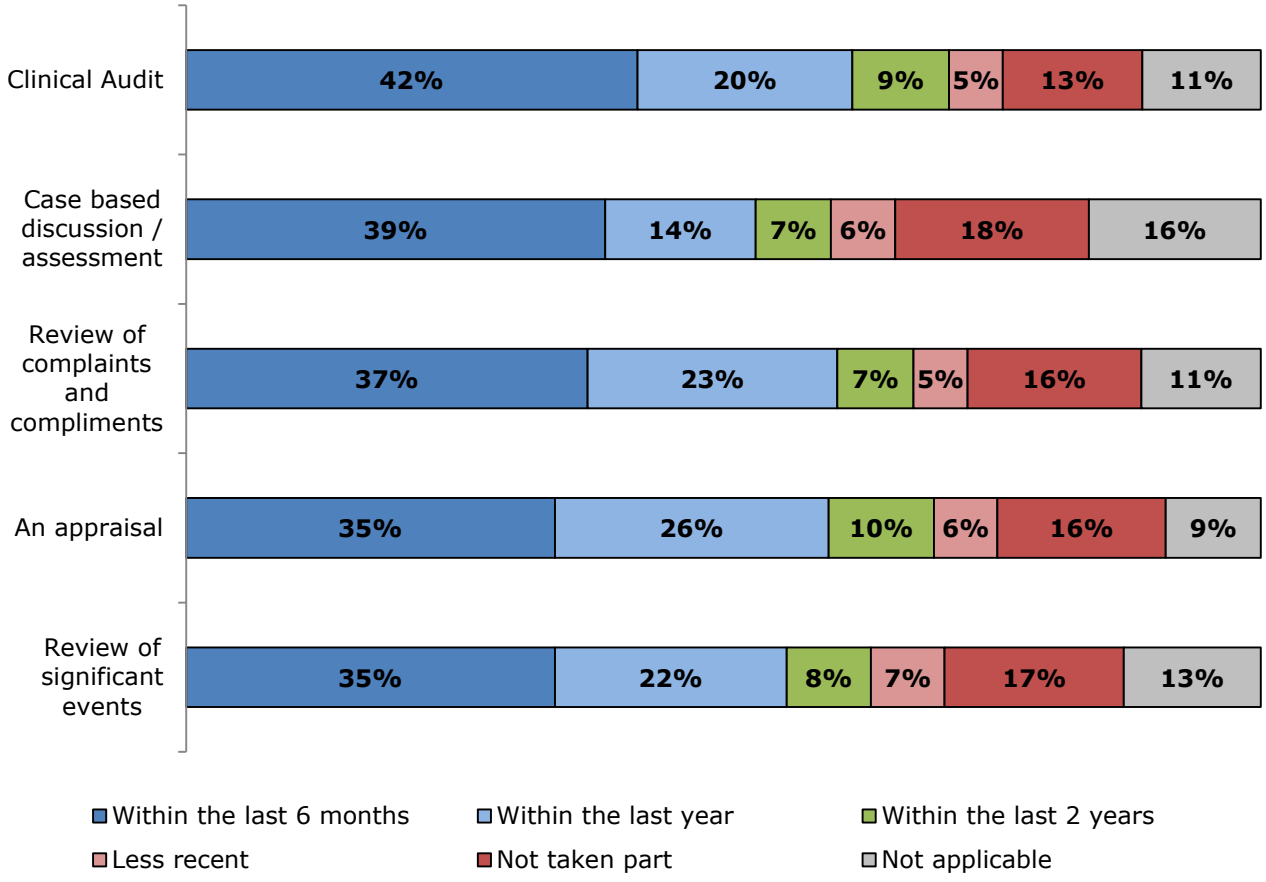
> *I think it's a good idea for new nurses. I think for somebody who's just qualified, to be able to sit down with their practice manager and plan a five year plan, is a very good idea so that they understand that they've got to do this five year CPD cycle, so they understand indemnity, so they know about verifiable/non-verifiable, all of that, so they get all of that.*
>
> (Dental nurse, focus group, Reading)

2.7 Appraisal / Evidence Types

This year's Annual Survey asked respondents to indicate whether they had taken part in any activities relating to appraisals, audits, assessments and evidence types.

The results show that the largest proportion of respondents had undertaken each activity within the last six months, from clinical audits being undertaken by 42% and appraisals and a review of significant events being undertaken by 35% each.

Figure 31 – Please indicate whether you have taken part in any of the following activities, and if so, how recently this was
Base: All respondents (3,611)



Analysis of key subgroups shows that a larger proportion of dental nurses had undergone an appraisal within the last six months at 39% (compared to 42% overall). A larger proportion of dentists, however, indicated that they had undertaken all other activities within the last six months, with clinical audits at 51% (42% overall), case based discussion/assessment at 56% (39% overall), review of significant events at 42% (35% overall) and review of complaints and compliments at 43% (37% overall).

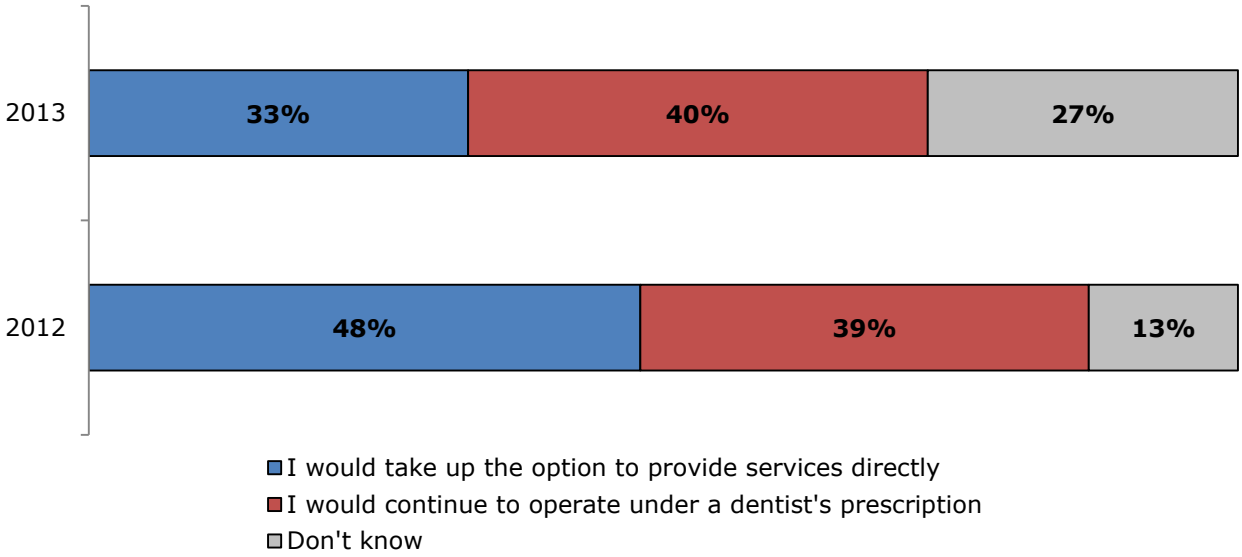
2.8 Direct Access

Since the 1 May 2013, the GDC has removed its barrier to Direct Access for some dental care professionals after considering the impact on patient safety. In the past every member of the dental team had to work on the prescription of a dentist. This meant that patients had to be seen by a dentist before being treated by any other member of the dental team. Since the change, registered dental care professionals have the option to provide directly to patients, any care assessment, treatment or procedure that is within their scope of practice and for which they are trained and competent.

All DCP survey respondents were asked whether they would personally take up the option to provide services directly to patients, subject to being trained and competent, or whether they would continue to operate under a dentist's prescription. As shown in **Figure 32** below, a third of respondents said that they would take up the option to provide services directly (33%), with the largest proportion stating that they would continue to operate under a dentist's prescription (40%).

This question was also asked in the 2012 Annual Survey of Registrants before the GDC removed its barrier to allow DCPs to provide directly to patients, therefore meaning that the question was hypothetical. As can be seen in the chart below, a significantly larger proportion of DCP respondents said that they would take up the option to provide services directly at 48% (compared to 33% in 2013). Almost the same proportion of respondents indicated that they would continue to operate under a dentist's prescription, showing that there was a significant increase in respondents stating that they did not know between 2012 and 2013 (+14%). The hypothetical nature of the question in 2012 may explain these differences in results, but other explanations were offered by registrants in the qualitative research which may also have influenced survey responses.

Figure 32 – Thinking about your future plans, would you personally take up the option to provide services directly, subject to being trained and competent, or would you continue to operate under a dentist's prescription?
Base: All DCP respondents – 2013 (2,191) / 2012 (2,533)



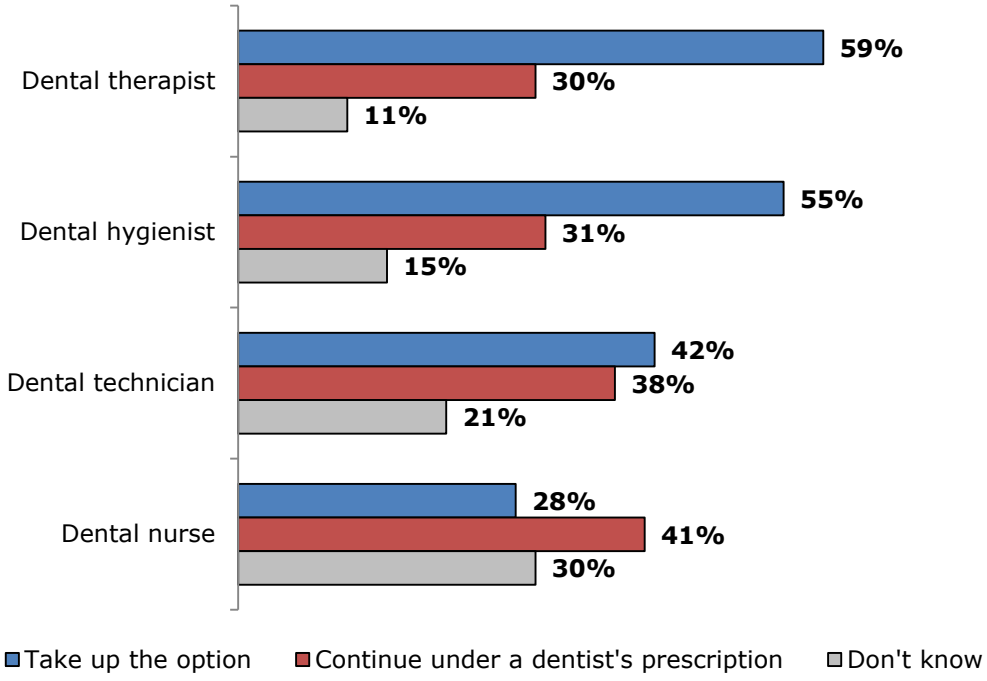
A larger proportion of DCP respondents who had been registered with the GDC for a longer period of time said that they would take up the option to provide services directly, suggested by 43% of those registered for 21 years and over. A larger proportion of male

DCPs indicated that they would take up the option to provide services directly at 48% compared to female respondents at 32%.

Figure 33 shows which DCP groups were most in favour of taking up the option to provide services directly to patients. Dental therapists were more likely to indicate that they would take up the option at 59%, followed by 55% of dental hygienists and 42% of dental technicians. The majority of dental nurses, however, indicated that they would continue to operate under a dentist's prescription at 41%. A significantly larger proportion of dental nurses also answered that they did not know at 30%.

When compared to the 2012 results a decrease in the proportion of each role indicating that they would take up the option can be seen. For example, 78% of therapists and 66% of hygienists indicated that they would take up the option in 2012, which shows a decrease of -19% and -11% respectively for these groups when compared to the 2013 results.

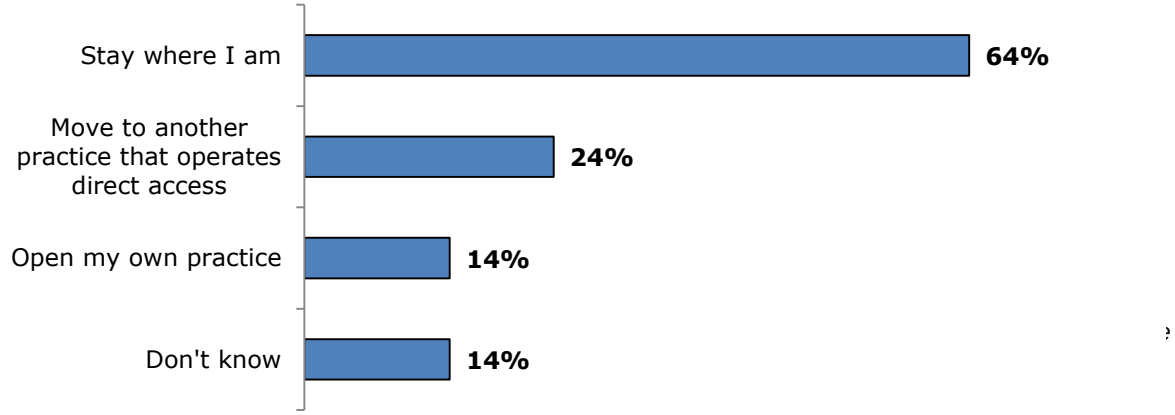
Figure 33 – Take up the option to provide services directly by DCP group
Base: Dental therapists (100) / hygienists (261) / technicians (219) / nurses (1,650)



In this year's survey, DCP respondents who indicated that they would take up the option to provide services directly were additionally asked where they would plan to practise. Respondents were able to select more than one option. **Figure 34** overleaf shows that the majority of respondents said that they would stay where they were (64%), followed by 24% who would move to another practice that operates direct access and a further 14% said that they would open their own practice.

A larger proportion of dental hygienists said that they would stay where they were (72%), compared to dental nurses who were more likely to state that they would move to another practice (30%) and dental technicians who were more likely to say that they would open their own practice (29%).

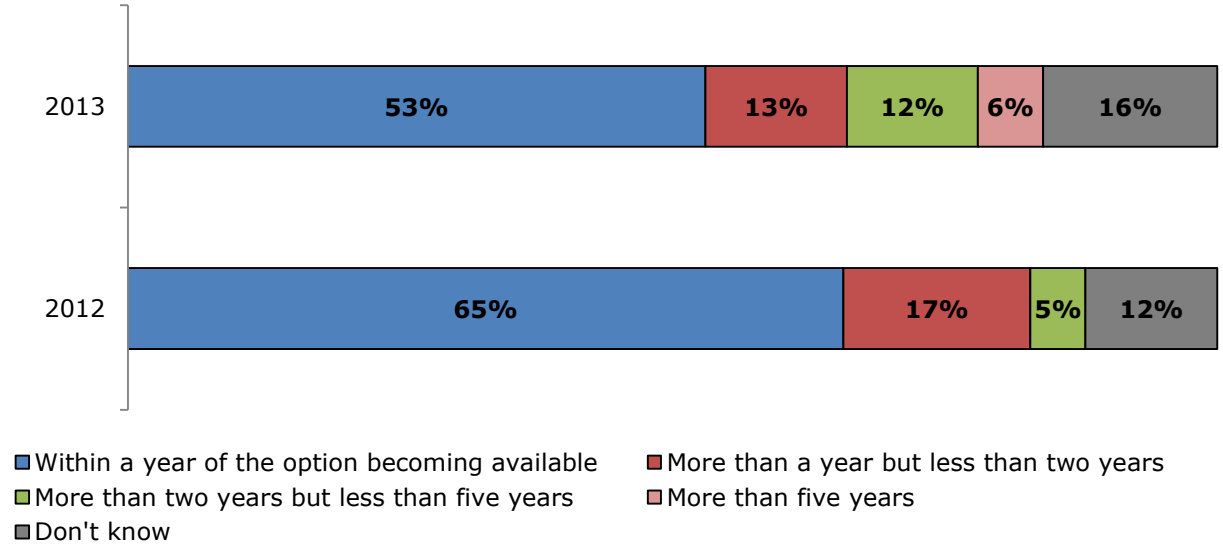
Figure 34 – Where would you plan to practise?
Base: Respondents who would take up the option to provide services directly (728)



As in the 2012 Annual Survey, DCP respondents who indicated that they would take up the option to provide services directly were also asked when they would take up the option. **Figure 35** shows that for all DCP groups, just over half would take up the option within a year of it becoming available (53%). In comparison to the results from 2012, this shows a decrease of 12%, with a larger proportion of respondents in 2013 stating that they would take the option up within more than two years but less than five years (12%, +7%), within more than a year but less than two years (6%, +6%) and that they did not know when they would take up the option (16%, +4%).

Again, it is important to remember that when this question was asked in 2012, the option for Direct Access was not currently available, meaning that the question was hypothetical.

Figure 35 – If the option to provide services directly becomes available, when do you think you would take up the option?
Base: Respondents who would take up the option to provide services directly – 2013 (728) / 2012 (1,216)



A larger proportion of dental hygienists indicated that they would take up the option of direct access within a year of it becoming available at 58% (compared to 53% overall).

Qualitative findings

Direct Access was discussed with DCP respondents who took part in the qualitative research in order to better understand how the option was affecting those who had taken it up, or those who were working in a practice where the option had been taken up, and to explore how the option was viewed now that it was in place.

Experience of Direct Access and its benefits

Only a small number of participants indicated that they were currently or had some experience of utilising the direct access option to provide services directly to patients. However, all participants were aware of Direct Access and had strong views on it. In general it was agreed that Direct Access was a good idea in principle as it had various benefits for both the patient and the profession. In terms of benefits and advantages for patients, it was suggested that Direct Access provided a greater range of choice and options, for example allowing them to not have to see a dentist if they do not feel it is necessary for their needs, allowing them to pay less for their treatment. It was also suggested that Direct Access could have the added benefit of encouraging the public into regularly using dental services, as DCPs could refer patients on to a dentist if they have fallen out of the habit of doing so.

> *I do use it within the surgery, but not alone when there isn't a dentist around. I love it. It's what I've always wanted to do.*
>
> (Dental therapist, depth interview, England)

> *It removes the barriers to access for patients. They can get a scale and polish if they want it and not have to see the dentist and get ripped off when they don't need to.*
>
> (Hygienist, depth interview, Scotland)

> *It could help get patients back into the habit of seeing a dentist regularly. They come and see us for their hygiene and then we can encourage them to see the dentist.*
>
> (Dental therapist, depth interview, England)

For dental professionals, participants identified benefits of Direct Access for those who wanted to become their own boss and not have to work alongside dentists, allowing them to create their own business and take a greater share of any profits made. However, it was felt that, for those who were not interested in branching out alone who wanted to continue to work alongside dentists within a practice, the benefits were less clear.

> *If gives patients more of a choice, and it can make you your own boss.*
>
> (Dental hygienist, focus group, Nottingham)

> *It's harder to say what the benefits for the staff are. It will free up the dentist and will mean therapists can get more experience.*
>
> (Dental hygienist, focus group, Nottingham)

Barriers to Direct Access

Whilst the majority of DCP participants explained that they thought Direct Access was a good idea in principle, a number of barriers were discussed as to why many DCPs may not take up the option.

Firstly, a number of participants said that the wording set out in the GDC's guidance was vague and unspecific as it related to how confident and competent the individual felt, which they felt was very much open to interpretation, subjective and could differ greatly between dental professionals. They felt that this wording did not make them feel

confident enough to take up the option of Direct Access as they were too concerned that, should anything go wrong, they would be held seriously accountable for not being sufficiently competent and could very easily 'get into trouble'. It was, therefore, suggested that it should be made very clear what requirements are necessary to provide services directly to patient in terms of experience and skills to avoid any ambiguity, which would allow DCPs to feel more confident as they would feel more secure in their abilities.

> *It could potentially get you into a lot of trouble. A hygienist might feel confident but in reality they might not have the skills.*
>
> (Dental nurse, depth interview, Northern Ireland)

> *It's all still very vague in the standards which will make people unsure. The wording needs to be black and white. It should say you need to fulfil X Y and Z and have certification for it. Competence is so subjective – I may feel competent but does my boss?*
>
> (Hygienist, depth interview, Scotland)

> *It's the term 'within your scope of practice'. Rather than us feeling that it is it would be nice to have a way to prove that it's in our scope of practice so we have a certificate for it and we could show it to patients. But it's all very vague. You don't feel you're protected by the GDC because it's not specific to your role.*
>
> (Dental therapist, focus group, Nottingham)

It was suggested that the perceived ambiguity around the rules of Direct Access made DCPs feel as though the GDC was not fully committed to the idea as it was providing the option but not being too specific on the criteria required or providing any reassurances to encourage DCPs to take it up. It also meant that any DCPs who wanted to attempt to use Direct Access were in an unsure situation.

> *There are so many pitfalls and loop holes with the explanation in the scope of practice that you kind of feel like you're being told that yes you can go ahead with it but if you do this then you could get in trouble and face litigation. So you really want to go for it, but they're still holding back on certain things. You're kind of one foot in and one foot out.*
>
> (Dental therapist, focus group, Nottingham)

> *It's not detailed enough so it's all a bit awkward and unsure. I think it's because in reality the GDC don't really want to give it to us, they were forced by trading standards.*
>
> (Hygienist, depth interview, Wales)

It was also highlighted that the standards and guidance around Direct Access was often restrictive, particularly around the issue of DCPs providing local anaesthetic which participants explained was not currently included. This inability to prescribe local anaesthesia meant that those wanting to provide Direct Access had to go back to the dentist to be able to do so, as many of their procedures required it, making things difficult for them. Again, this led some participants to question the GDC's commitment to Direct Access and whether they actually wanted DCPs to take up the option.

> *Without the ability to administer local anaesthetic it's often a fool's errand. I need it and can't do a lot without it, so I can't see the majority of patients under Direct Access as I'm constantly going back to the dentist.*
>
> (Hygienist, depth interview, Wales)

A further barrier suggested was that many DCPs simply did not feel confident enough to take up the option of Direct Access, particularly younger and less experienced hygienists and therapists. It was felt that this lack of confidence was exacerbated by the perception of many DCPs that, should they make a mistake, they would get into serious trouble, and that someone may simply be waiting for them to do so. It was also highlighted that it was difficult for many DCPs to enhance their experience and increase their confidence due to some dentists' reluctance to facilitate Direct Access.

> *A lot are scared to do it. Especially young therapists who don't have enough experience.*
>
> (Dental therapist, depth interview, England)

> *They are still nervous of doing it…they've always worked under the safety net of actually having a dentist and now they're doing it on their own. They've always checked medical histories…but now they're completely on their own doing it. I think it's because that as an industry we tend to feel that there is someone out there to get us and they're maybe just feeling a little bit more vulnerable now.*
>
> (Dental nurse, focus group, Reading)

> *Dentists don't like it. So it's hard for them to get experience because they don't allow them to do it.*
>
> (Dental therapist, depth interview, England)

Linked to lack of confidence and experience as a barrier to taking up the option of Direct Access, another barrier suggested was the lack of training to support DCPs who were interested in taking up the option. It was highlighted that, by providing specific training relating to Direct Access, a standardised level of experience, knowledge and skill would be achieved which would go a long way towards improving the confidence of DCPs interested in taking up the option, and which would also ensure patient safety.

> *There needs to be more training offered to support it on the way, I'm not sure it's quite there yet.*
>
> (Dental therapist, depth interview, England)

> *Direct Access has extended to doing radiographs, but it hasn't extended the CPD courses to extend my knowledge of it specifically for therapists. The training needs to be there to support it.*
>
> (Dental therapist, depth interview, England)

A number of participants explained that they had originally expected Direct Access to come hand in hand with mandatory training and upgrading of skills, and were surprised to see that it did not when it was introduced, which deterred them from taking up the option. Therefore, some participants went further, suggesting that all DCPs interested in providing Direct Access should undergo mandatory training in order to upgrade their knowledge and skills to a required level, and that this should be set out in the GDC's standards to make it completely clear what needed. They explained that, when compared to the levels of experience and training dentists are required to have to perform some of the same procedures, their level of training was far less, and that allowing Direct Access without further training would undermine dentists' authority. Again, it was felt that mandatory training would inspire greater confidence in DCPs and patients.

> *I was really in favour of direct access but expected that I would have to upgrade my skills to use it. I was prepared to retrain before providing directly. I have experience of treating gum disease but it isn't enough. I've spent 12 months contacting dental schools to see if there are any courses to prepare you for Direct Access…there are no courses available in Britain. It ridicules the profession.*

Dentists have to complete a five year degree and I did a nine month course. Therefore we shouldn't treat patients directly without additional training.

(Hygienist, depth interview, Scotland)

Direct Access would work if there were mandatory requirements. It's for the safety of the patient, they deserve better than that. I don't think the GDC have done their homework with this, but it is a good way forward. We all saw it as a good idea but then suddenly a lot of my colleagues got second thoughts.

(Hygienist, depth interview, England)

Another barrier highlighted was the difficulty of providing Direct Access within the NHS. It was discussed that, at the moment, procedures and regulations were too restrictive to allow DCPs to provide directly to patients as, for example, a dentist was required to open and close any UDAs. Participants therefore felt that Direct Access had not been thought through at this level and that it required significant changes to be made to allow it to be opened up to the NHS setting and not just confined to private practice.

They need to work on allowing direct access in the NHS.

(Dental therapist, focus group, Nottingham)

It wouldn't really work in the community setting. It's set in stone how things work and our hygienist and therapist would still have to work under the prescription of the dentist.

(Dental nurse, depth interview, Northern Ireland)

One of the main barriers is the NHS. It doesn't work there because a dentist has to open and close a UDA, it can't be done by a hygienist, so it falls flat on its face.

(Hygienist, depth interview, Wales)

Finally, it was suggested that public awareness of the ability for DCPs to provide services directly to patients, which it was felt was low, was a further barrier. Participants explained that this meant patients may simply be unaware that they can book an appointment with a hygienist or therapist instead of a dentist. It was also felt that there was general confusion amongst patients as to what the role of a dental therapist involved altogether. Therefore, a number of participants suggested that more could be done to promote the various roles within dentistry to the public, including what services each role can offer, particularly if Direct Access is to become taken up by an increasing number of DCPs, and that the GDC could have responsibility for doing this.

I have a friend who's a therapist and she mentions that patients are often confused as to what her role is. They think she's a dentist. They get frustrated when she can't do things because they like her and want her to do it. It can cause problems and patient awareness needs to be raised with regards to the Direct Access options available to them so they can make informed choices.

(Dental technician, focus group, Nottingham)

It would be good if they could provide a chart or something to patients so they can see who in the practice can provide them with what service so they can decide for themselves.

(Dental therapist, focus group, Nottingham)

The GDC need to take a role in promoting the role of the therapist more. And the dentist too, they need to let patients know that they can visit the therapist and what they can do.

(Dental hygienist, focus group, Nottingham)

It was generally agreed that these barriers would explain why smaller proportions of survey respondents indicated that they would take up the option of Direct Access in the survey results when compared to the 2012 results.

2.9 Raising a Concern

2.9.1 Experience of raising a concern

The GDC standards guidance states that dental professionals must raise a concern if patients might be at risk for the following reasons:

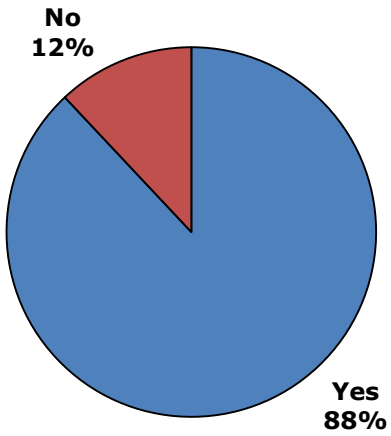
(i) The health, behaviour or professional performance of a colleague
(ii) Any aspect of the environment where treatment is provided
(iii) Someone asking you [a dental professional] to do something that conflicts with your duties to put patient interests first and act upon them

The following questions in this chapter of the report relating to raising concerns were new additions to the Annual Survey of Registrants 2013.

All respondents were asked whether they would know where to go if they wanted to raise a concern about poor standards of care. As seen in **Figure 36** below, almost nine in ten respondents said that they would know where to go (88%) and just 12% said that they would not know.

Subgroup analysis highlights that a larger proportion of dental technicians and dentists indicated that they would not know where to go if they had a concern at 23% and 15% respectively, as did respondents who lived in Scotland and Northern Ireland at 17% and 15% respectively.

Figure 36 – If you want to raise a concern about poor standards of care do you know where to go?
Base: All respondents (3,611)



Respondents were then asked to indicate how frequently, if ever, they had come across an issue that they felt should have been raised as a concern. As presented in **Figure 37** overleaf, over half of respondents said that they had never come across an issue (54%), followed by 22% who had come across an issue a few times (two to three times) and a further 16% who had come across an issue once. One in twelve said that they had come across an issue several times, which was defined as three or more times (8%). However, it is interesting to note that almost half of the survey sample (46%) had come across at least one issue at some stage during their career.

The sample shows that a significantly larger proportion of dental technicians and specialists said that they had come across an issue several times at 20% and 13% respectively (compared to 8% overall). Perhaps unsurprisingly, the sample also clearly

shows that the number of years registered with the GDC has an impact on the likelihood of having come across an issue, with 75% of those who had been registered for less than a year saying that they had never come across a concern, consistently falling to 40% for those who had been registered for 21 years and over.

Figure 37 – How often, if ever, have you come across an issue that you feel should have been raised as a concern?
Base: All respondents (3,611)

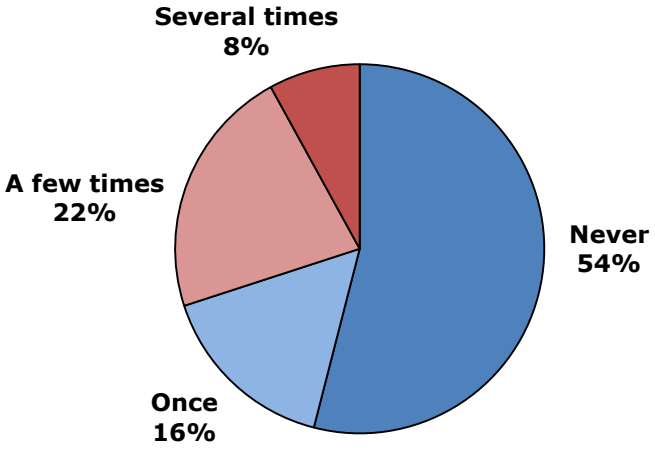


Figure 38 shows that two in five respondents said that they had raised a concern about the practise or behaviour of a dental professional to someone in their place of work (39%), and that just 5% had raised this type of concern to the General Dental Council.

A larger proportion of specialists and respondents who lived in Scotland said that they had raised a concern to someone in their place of work at 51% and 43% (compared to 39% overall). Dental technicians were more likely to state that they had not raised a concern to someone in their place of work at 69% (compared to 61% overall).

A larger proportion of specialists and dental technicians said that they had raised a concern about the practise or behaviour of a dental professional to the GDC at 15% and 10% respectively (compared to 5% overall). By comparison, dental therapists and respondents who lived in Wales were more likely to state that they had not raised a concern to the GDC at 99% and 98% respectively (compared to 95% overall). A larger proportion of male respondents said that they had raised a concern to the GDC at 7% compared to female respondents at 4%.

Figure 38 – Have you ever raised a concern about the practise or behaviour of a dental professional to…?
Base: All respondents (3,611)

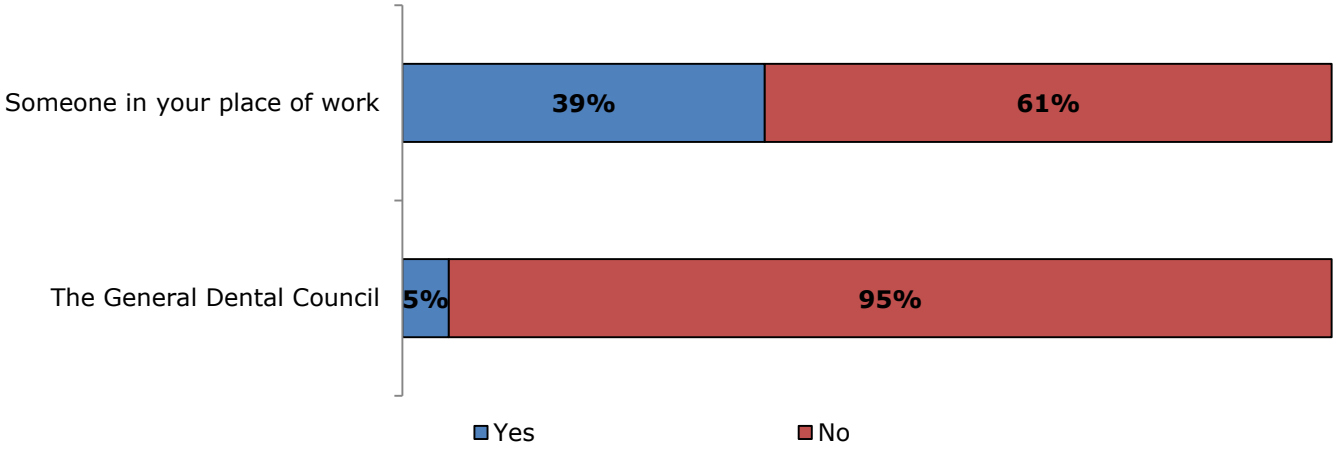


Table 12 below shows the percentage of respondents who had raised a concern to either someone in their place of work or to the GDC based on the number of times they had come across an issue that they felt should have been raised as a concern. Those who said that they had come across a concern sever times, a few times or once were significantly more likely to have raised an issue to both someone in their place of work and to the GDC. For example, 72% of respondents who indicated that they had come across an issue several times had raised a concern to someone in their place of work, and 19% had raised a concern to the GDC.

These results show that those who have come across an issue that they felt should be raised as a concern are far more likely to go to someone in their place of work rather than to the GDC.

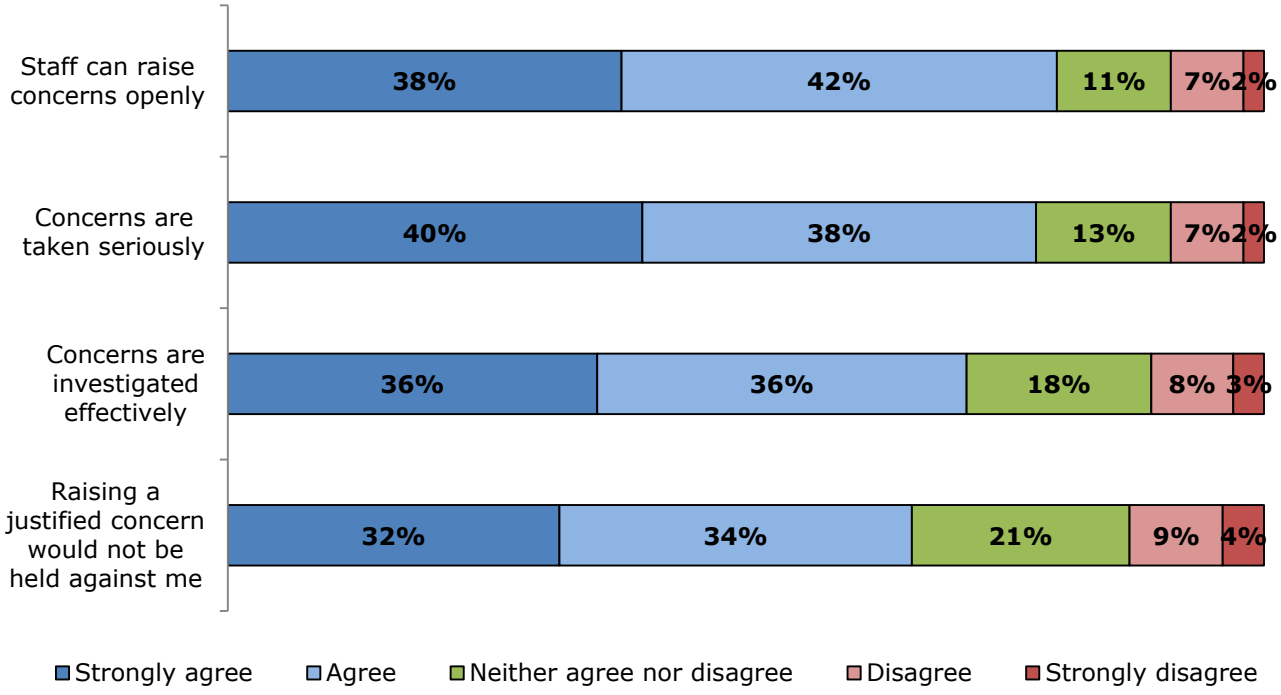
Table 12 – Raising a concern by frequency of coming across an issue that should be raised as a concern
Base: All respondents (3,611)

Raising a concern	Overall	Several times	A few times	Once	Never
Have raised a concern to someone in your place of work	39%	72%	68%	67%	14%
Have raised a concern to the GDC	5%	19%	8%	7%	1%

2.9.2 Raising a concern in the workplace

The survey asked respondents to indicate to what extent they agreed or disagreed with a series of statements regarding raising concerns in their place of work. As shown in **Figure 39**, the majority of respondents agreed with all statements.

Figure 39 – My workplace(s) is one/are ones where…
Base: All respondents (3,611)



A total of 80% of respondents agreed in some way that their workplace was one where staff can raise concerns openly (38% strongly agreed, 42% agreed) and 9% disagreed (7% disagreed, 2% strongly disagreed). Subgroup analysis highlights that a larger proportion of dental therapists and respondents who lived in Scotland disagreed with this statement at 12% and 14% respectively when compared with other roles. A larger proportion of those who worked in a community/community dental services setting also disagreed with this statement at 14% compared to other areas of work.

Almost four in five respondents (78%) agreed in some way that their workplace was one where concerns are taken seriously (40% strongly agreed, 38% agreed) and 9% disagreed (7% disagreed, 2% strongly disagreed). The sample shows that a larger proportion of respondents who lived in Scotland disagreed with this statement at 14% when compared with other areas. In relation to place of work, a larger proportion of respondents who worked in a hospital, in community/community dental services and in salaried primary care dental services also disagreed with this statement, each at 12%, when compared with other workplace settings.

Just over seven in ten respondents (72%) agreed in some way that their workplace was one where concerns are investigated effectively (36% strongly agreed and 36% agreed) and 11% disagreed (8% disagreed, 3% strongly disagreed). A larger proportion of respondents from Scotland (14%) and those working in community/community dental services (15%) and salaried primary care dental services (15%) indicated that they disagreed with this statement. However, a larger proportion of respondents who worked as part of a dental practice (75%) and who provided private care only (77%) agreed with this statement.

Two thirds of respondents (66%) agreed in some way that their workplace was one where raising a justified concern would not be held against them (32% strongly agreed and 34% agreed) and 13% disagreed (9% disagreed, 4% strongly disagreed). The sample highlights that a larger proportion of dental hygienists (17%), therapists (17%), those who lived in Scotland (18%), those working in community/community dental services (18%) and those working in a dental school/university/college/school disagreed with this statement (18%). Again, a larger proportion of those who indicated that they provided private care only said that they agreed in some way with this statement (70%).

It is interesting to note that, when looking at responses to this question, a larger proportion of those who had previously raised a concern about the practise or behaviour of a dental professional to someone in their place of work disagreed with each statement when compared to those who had not previously raised a concern. For example, 16% of those who had raised a concern disagreed that their workplace was one where concerns are taken seriously, compared to just 5% who had not raised a concern. These results are shown in **Table 13** below.

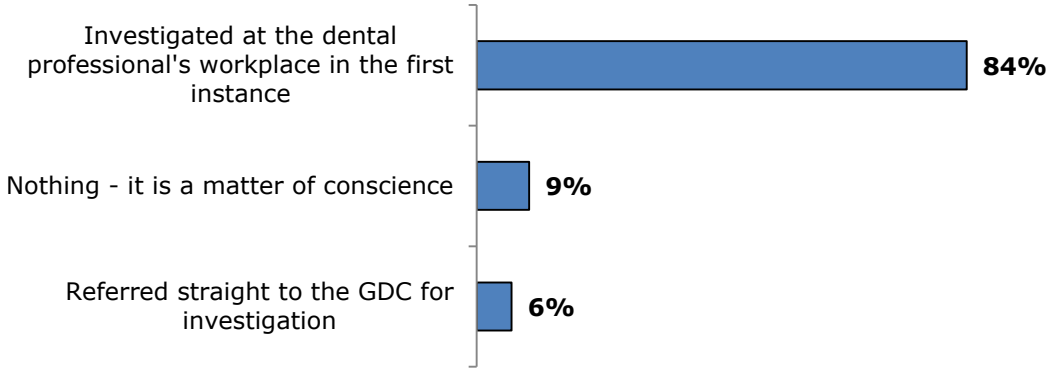
Table 13 – Disagreement with workplace statements by experience of raising a concern to someone in their place of work

My workplace is one where…	Overall disagreement	Those who had raised a concern	Those who had not raised a concern
Staff can raise concerns openly	9%	14%	7%
Concerns are taken seriously	9%	16%	5%
Concerns are investigated effectively	11%	17%	7%
Raising a justified concern would not be held against me	13%	18%	10%

All respondents were asked what they thought should happen to a dental professional who fails to report concerns about another dental or health professional. The majority of respondents said that they thought the matter should be investigated at the professional's workplace in the first instance (84%) and a further 9% said that nothing should happen as it is a matter of conscience. Just 6% said that the matter should be referred straight to the GDC for investigation.

Subgroup analysis shows that dental hygienists and therapists were more likely to suggest that the matter should be investigated at the dental professional's workplace in the first instance at 91% and 95% respectively. However, a larger proportion of dental technicians (20%), dentists (12%) and male respondents (14%) felt that nothing should happen and that it is a matter of conscience. Dental technicians were also slightly more likely to suggest that the issue should be referred straight to the GDC for investigation at 12%.

Figure 40 – What do you think should happen to a dental professional who fails to report concerns about another dental or health professional?
Base: All respondents (3,611)



Qualitative findings

Experiences of raising concerns
Many interview participants indicated that had experience of coming across an issue and also raising a concern and therefore found the survey result that 46% of respondents had come across an issue at least once about right, if not slightly low.

Just one participant indicated that they had raised their concern with the GDC, but that they were satisfied with the outcome. The majority of participants who had raised a concern had done so in the workplace. Experiences of this were mixed, with some participants explaining that the issue was resolved, but others stating that their experience was poor. Two respondents in particular explained that, as a result of raising a concern in their workplace, they were branded as a 'trouble-maker' and ostracised by other staff. This had led them to the firm opinion that they would not raise any other concerns in the future.

> *I was quite happy with the way the GDC dealt with our concerns.*
> (Dental nurse, depth interview, England)

> *I raised a concern with something I didn't agree with and was branded a trouble maker. Now I just keep my head down and leave them to it. They see nurses as a dime a dozen so they don't get listened to.*
> (Dental nurse, depth interview, Wales)

I wouldn't bother raising a concern in the future because what's the point? You just get made out to be a trouble maker. It was a terrible process.

(Orthodontic therapist, depth interview, England)

It was, therefore, generally accepted that raising concerns could be very difficult. Whilst a number of participants stated that they had previously raised concerns, they conceded that not all dental professionals would feel confident to do so, particularly dental nurses who have a significant responsibility to blow the whistle on their employers now that they are registered with the GDC. It was seen as especially difficult for those raising concerns about their employers, with participants explaining that they would be fearful of losing their job as a result.

It's hard because the person you're raising a concern about might be paying your wages. How far do you go if there's a chance of losing your job? Will you still be able to pay your mortgage, so is it worth it? It needs to be anonymous, but that could lead to people raising concerns willy-nilly.

(Dental technician, depth interview, Scotland)

I've come across a couple of things over the years which I've raised with my employer. They didn't deal with it and I wasn't happy so I went to the PCT. But I'm a confident person, I think others would be less inclined to do so because they're worried about what might happen to them.

(Hygienist, depth interview, Scotland)

Whistleblowing is very difficult, particularly for nurses. They can be in a difficult position, especially if the concern is about their employer. It's a big responsibly for them to have, especially when some are very young.

(Dentist, depth interview, England)

Resolving at the workplace or with the GDC

All interview participants said that they would attempt to deal with a concern in house at their place of work in the first instance before thinking of raising the issue with the GDC, and there was also a general consensus amongst participants that if an issue was deemed to be severe enough then they would take it directly to the GDC.

It was generally felt that it was better to resolve concerns this way as taking a concern to the GDC was seen to be a last resort and a step only to be taken if all other possibilities have not resolved the concern. A number of participants explained that they thought that if they took a concern to the GDC it would likely lead to very serious action being taken, and that this could potentially be disproportionate in relation to the concern that was raised such as ending a dental professional's career. For example, it was suggested that certain concerns could be resolved in the workplace by implementing further training or retraining. It was also suggested that addressing concerns in the workplace first should be the correct procedure for most issues as it would avoid any unnecessary time and money being spent to resolve something at a high level.

Any concerns I've had I've dealt with in house or with the protection society. I've never raised anything to GDC level. You don't want to open a can of worms if it can be sorted out in house. You make a judgement at the time.

(Dentist, depth interview, Northern Ireland)

I think everything should be dealt with at work first. The moment you call the GDC that's it, it will be investigated. It should be looked at locally first.

(Hygienist, depth interview, Scotland)

> *I'd always leave the GDC as a last resort. If I thought the patient was in danger then I'd have to go to them. But the GDC don't go in half-baked – you wouldn't go to them with just a suspicion. You'd go somewhere friendlier first. The GDC see things in black and white and if you go there you could possibly bring an end to someone's career or your own.*
>
> (Dentist, depth interview, Northern Ireland)

Whilst the consensus was that concerns should first be raised within the workplace, it was agreed that if a concern was severe then it could be taken directly to the GDC. When asked to elaborate on what they thought constituted a severe or major concern, examples of drug and alcohol abuse, criminal activity and serious patient neglect were suggested. However, it was accepted by the majority of participants that the severity of a concern was difficult to define until you experienced it, but that it would likely relate to serious patient harm. It was also felt that, because it was hard to define, guidance related to raising concerns was vague, but participants accepted that it would be difficult to change to make it more appropriate.

> *A major concern would be if someone was self-prescribing or taking drugs.*
>
> (Dentist, depth interview, Northern Ireland)

> *It would have to be serious patient neglect to be a major concern.*
>
> (Dentist, depth interview, England)

> *One person's concern is another person's non-concern – it's very hard to define! You could only really define it if patients were coming to harm. The guidance isn't really clear – it's a vague statement.*
>
> (Hygienist, depth interview, Scotland)

Therefore, participants generally felt that they would contact the GDC directly if they had a very serious concern, or would go to them as a last resort after exploring other avenues such as their workplace and their protection society.

> *If it is about patient neglect and substandard treatment then it should go to the GDC. Like drug and alcohol abuse and anything that can cause serious harm.*
>
> (Dental nurse, depth interview, England)

> *We would always deal with things internally. I can't see us going to the GDC unless the concern was criminal.*
>
> (Dentist, depth interview, Wales)

2.9.3 Confidence in regulators when concerns are raised

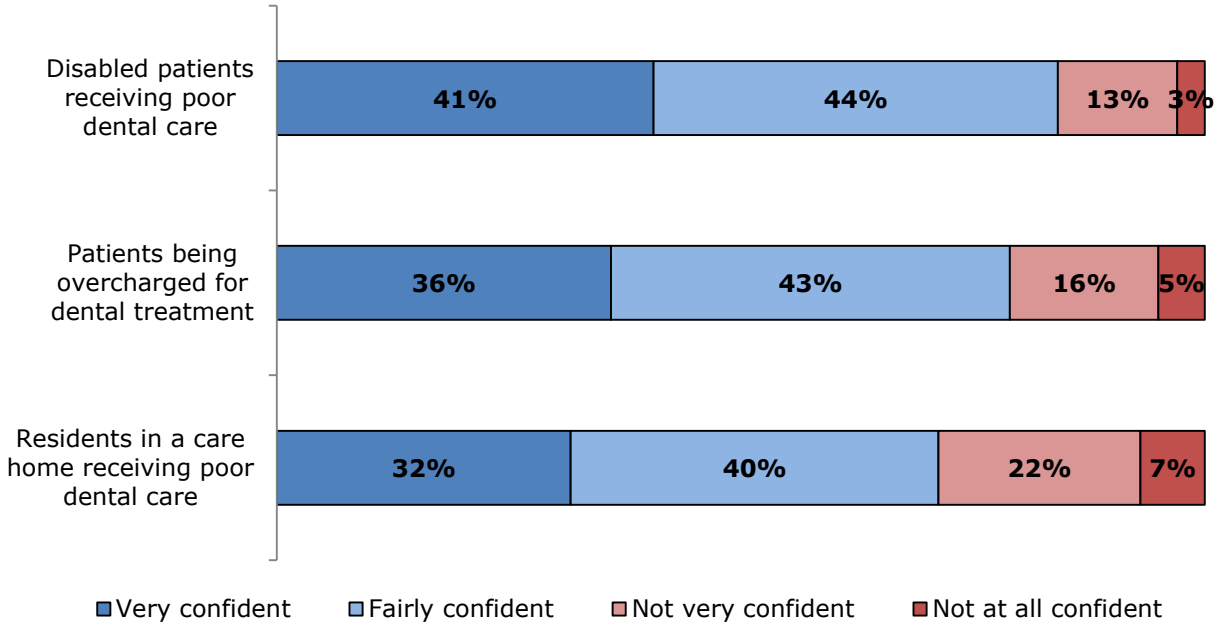
The survey provided respondents with three situations where poor care or serious wrongdoing may occur and asked them to indicate for each how confident, if at all, they were that appropriate action would be taken by a regulator. It is positive to note that, for all three situations, the majority of respondents said that they were in some way confident.

A total of 85% of respondents were confident that appropriate action would be taken if disabled patients received poor dental care (41% very confident, 44% fairly confident). A further 13% said that they were not very confident and just 3% that they were not at all confident. A larger proportion of dental nurses indicated that they were confident action would be taken at 90% when compared to dentists (79%) and specialists (69%). A smaller proportion of respondents who lived in Northern Ireland were confident that action would be taken, at 75% compared to other areas.

A total of 79% of respondents indicated that they were confident that appropriate action would be taken if patients were being overcharged for dental treatment (36% very confident, 43% fairly confident). A further 16% were not very confident and just 5% were not at all confident that appropriate action would be taken. A significantly larger proportion of dental technicians and those who provided private care only were not confident that appropriate action would be taken in this situation at 53% and 27% respectively (compared to 21% overall).

A total of 72% of respondents indicated that they were confident that appropriate action would be taken if residents in a care home received poor dental care (32% very confident, 40% fairly confident). In comparison to the other situations, a larger proportion of respondents indicated that they were not confident, with a total of 29% (22% not very confident, 7% not at all confident). In relation to dental professional group, larger proportions of dental technicians (38%), dentists (35%) and specialists (48%) said that they were not confident that appropriate action would be taken, whereas a larger proportion of dental nurses indicated that they were confident (79%). The sample also shows that a larger proportion of respondents who worked in a hospital and respondents who lived in Northern Ireland said that they were in some way not confident that appropriate action would be taken in this situation (both at 37%).

Figure 41 – For each situation, please indicate how confident, if at all, you would be that appropriate action would be taken by a regulator
Base: All respondents (3,611)



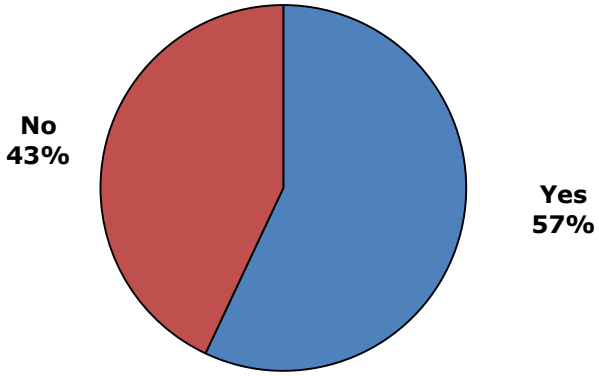
This question was also asked as part of the GDC's Patient and Public survey, which found that for each statement, registrants were more likely to be confident that appropriate action would be taken by a regulator when compared to the views of patients and the public. For example, a total of 51% of patient and public respondents stated that they were confident that action would be taken if disabled patients received poor dental care, whereas 85% of registrant survey respondents were confident (a difference of 34%).

2.9.4 Education, training and confidence levels

Respondents who had registered with the GDC in the last five years were asked whether their education course had covered how to raise concerns about poor standards of care. As shown in **Figure 42** below, almost three in five of these respondents (57%) said that raising a concern had featured in their education course, but a significant minority of 43% said that it had not.

A larger proportion of dentists (61%) and dental hygienists (74%) indicated that this had been covered in their education course, particularly when compared to dental technicians (33%). The sample also shows that a larger proportion of Asian or Asian British respondents had covered raising concerns about poor standards of care during their education course (64%).

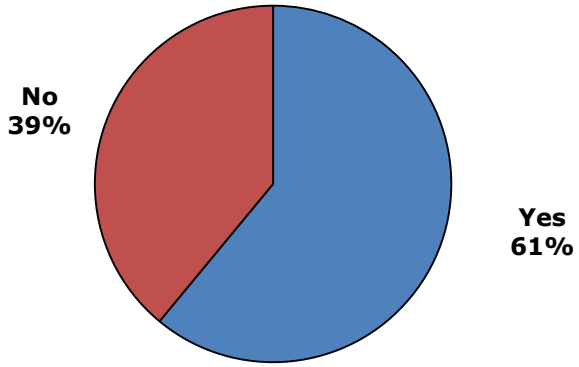
Figure 42 – Before your registration, did your education course cover how to raise concerns about poor standards of care?
Base: Respondents who registered with the GDC in the last five years (1,941)



All respondents were asked whether raising a concern about poor standards of care had featured in their training since registration. **Figure 43** overleaf shows that three in five respondents (61%) said that raising a concern about poor standards had featured in their training, but again that a significant minority of 43% said that it had not.

When looking at dental professional groups, a larger proportion of dental nurses indicated that this had featured in their training at 66%, whereas larger proportions of dental technicians (54%), therapists (46%) and dentists (42%) said that it had not featured in their training. Larger proportions of respondents who lived in Scotland (48%), Wales (51%) and Northern Ireland (51%) also said that raising a concern had not featured in their training, particularly when compared to respondents who lived in England (36%).

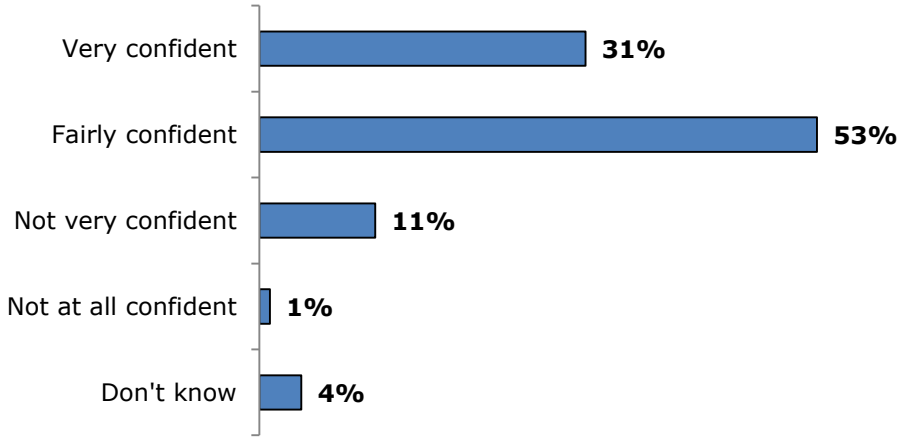
Figure 43 – Has raising a concern about poor standards of care featured in your training since registration?
Base: All respondents (3,611)



Finally, on the topic of raising concerns, all respondents who had indicated that raising a concern had featured in either their education or training were asked how confident they would feel about raising a concern about poor standards of care as a result of their education or training. The majority of respondents were in some way confident (a total of 84%), as 53% said they were fairly confident and 31% were very confident. A total of just 12% said that they were not very confident (11% not very confident and 1% not at all confident). These results are shown in **Figure 44** below.

Analysis of relevant subgroups highlights that a larger proportion of dental therapists (89%), hygienists (87%), nurses (86%) and specialists (90%) were in some way confident about raising a concern, particularly when compared to dental technicians (71%) and dentists (82%). In terms of location, the sample shows that larger proportions of respondents who lived in Scotland (19%) and Wales (19%) were in some way not confident about raising a concern (compared to 12% overall). We can also see that male respondents were more confident about raising a concern at 87% when compared to female respondents at 84%.

Figure 44 – How confident would you feel about raising a concern about poor standards of care as a result of your education or training?
Base: Respondents who had covered raising a concern in either their education course or training (2,509)

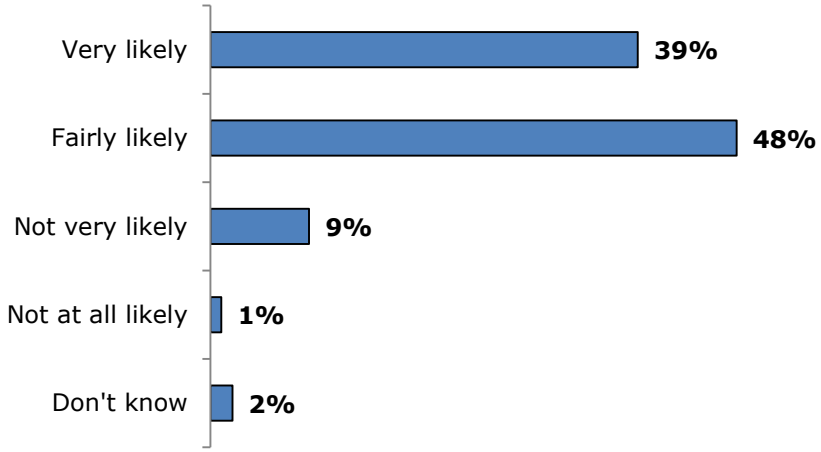


2.10 Providing an Explanation when Something has Gone Wrong

Survey respondents were asked to indicate how likely they thought it was that a dental professional would provide an explanation to a patient when something has gone wrong in their care or treatment (a new question for the 2013 Annual Survey). **Figure 45** below shows that a total of 87% thought that it was in some way likely (39% very likely, 48% fairly likely). Just one in ten indicated that it was in some way not likely (9% not very likely, 1% not at all likely).

Subgroup analysis highlights that a significantly greater proportion of dental technicians thought that it would not be likely for an explanation to be provided to a patient at a total of 29%, particularly when compared to dental hygienists and therapists, where a larger proportion stated that an explanation would be likely (92% for both). However, it is important to remember that many dental technicians have far less interaction with patients and the public, which may suggest that their answers reflect their perceptions of their colleagues rather than their own behaviour.

Figure 45 – How likely do you think it is that a dental professional would provide an explanation to a patient when something has gone wrong in their care or treatment?
Base: All respondents (3,611)



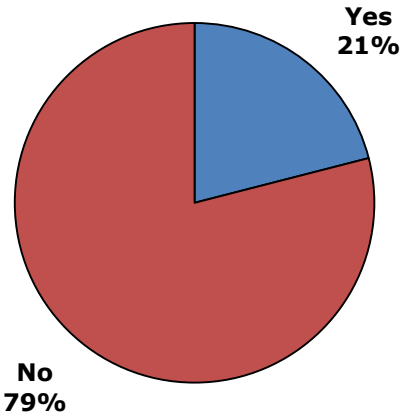
This question was also asked in the GDC's Patient and Public Survey 2013. These results show that 19% of respondents thought an explanation would be very likely (-20%) and a further 50% that it would be fairly likely (+2%). A larger proportion of patients and the public answered that it would not be very likely at 21% compared to dental professionals at 9% (+12%).

2.11 Checking Disciplinary Records

Survey respondents were asked if they had ever checked whether dental professionals they have worked with have had any disciplinary actions taken against them (a new question for the 2013 Annual Survey). As shown in **Figure 46** below, four in five respondents said that they had not done this (79%).

Subgroup analysis of the results highlights that dentists and specialists were much more likely to have checked at 26% and 37% respectively when compared to other dental professional groups. A smaller proportion of registrants who lived in Scotland and Wales indicated that they had checked at 16% and 12% respectively when compared with other areas.

Figure 46 – Have you ever checked whether dental professionals you have worked with have any disciplinary actions taken against them?
Base: All respondents (3,611)

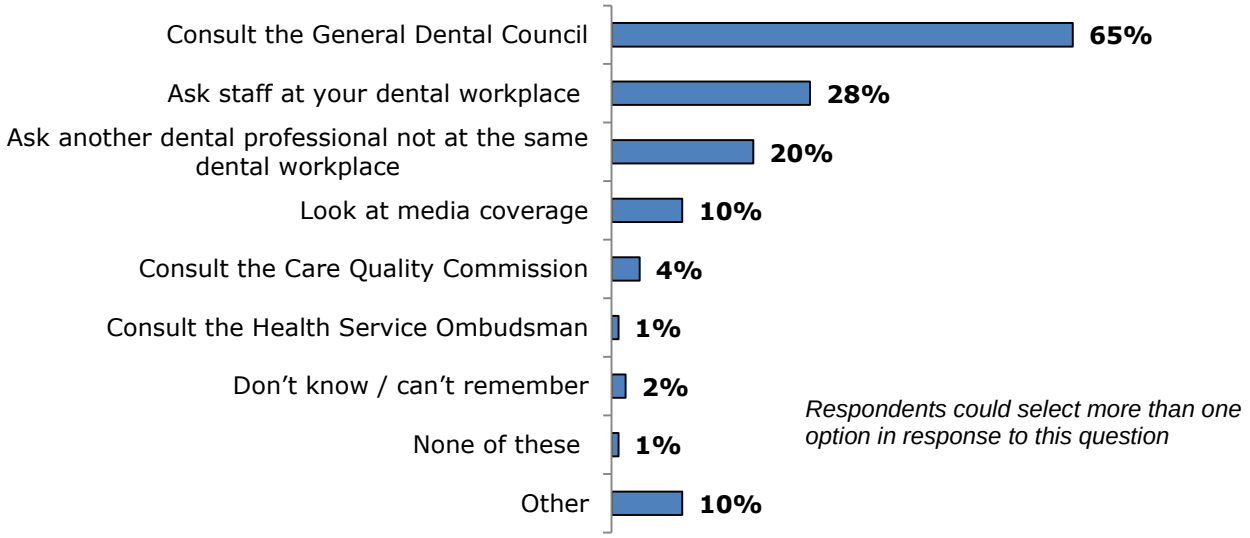


Those who indicated that they had checked whether dental professionals they have worked with have any disciplinary actions taken against them were then additionally asked how they had done this. Survey respondents were able to select multiple options in response to this question. The most common method suggested was consulting the General Dental Council at 65%, followed by 28% who indicated that they had asked staff at their dental workplace and a further 20% who had asked another dental professional outside their workplace.

'Other' responses included pre-employment checks, taking up references, procedures as part of the job application process, Criminal Records Bureau / Disclosure and Barring Service checks and checking with the local NHS. These results are shown in **Figure 47** overleaf.

A larger proportion of dental nurses indicated that they had consulted the General Dental Council at 68% when compared to dentists at 64%. The sample shows that dentists were more likely to ask another dental professional not at the same workplace (28%).

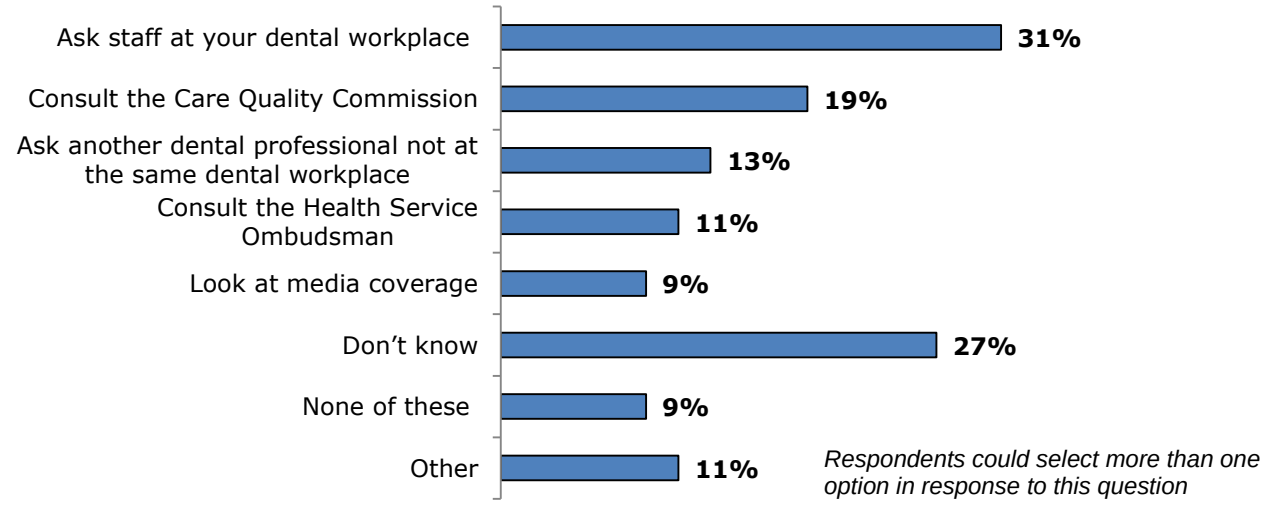
Figure 47 – How did you check this?
Base: Respondents who <u>had</u> previously checked whether dental professionals they have worked with have had any disciplinary actions taken against them (758)



Those who indicated that they had not checked whether dental professionals they have worked with have any disciplinary actions taken against them were asked if they were to check, how they would do it. Survey respondents were able to select multiple options in response to this question. The most common method suggested was asking staff at their dental workplace at 31% followed by a further 19% who said that they would consult the Care Quality Commission. Almost all 'other' responses related to checking with the General Dental Council. These results are shown in **Figure 48**.

A larger proportion of dental nurses indicated that they would consult the Care Quality Commission at 23%, whereas a larger proportion of dentists said that they would ask another dental professional not at the same dental workplace (17%). A smaller proportion of registrants from Scotland and Wales indicated that they would consult the Care Quality Commission (both at 11%) compared to other areas.

Figure 48 – If you were to check whether action was taken, how would you do this?
Base: Respondents who <u>had not</u> previously checked whether dental professionals they have worked with have had any disciplinary actions taken against them (2,853)



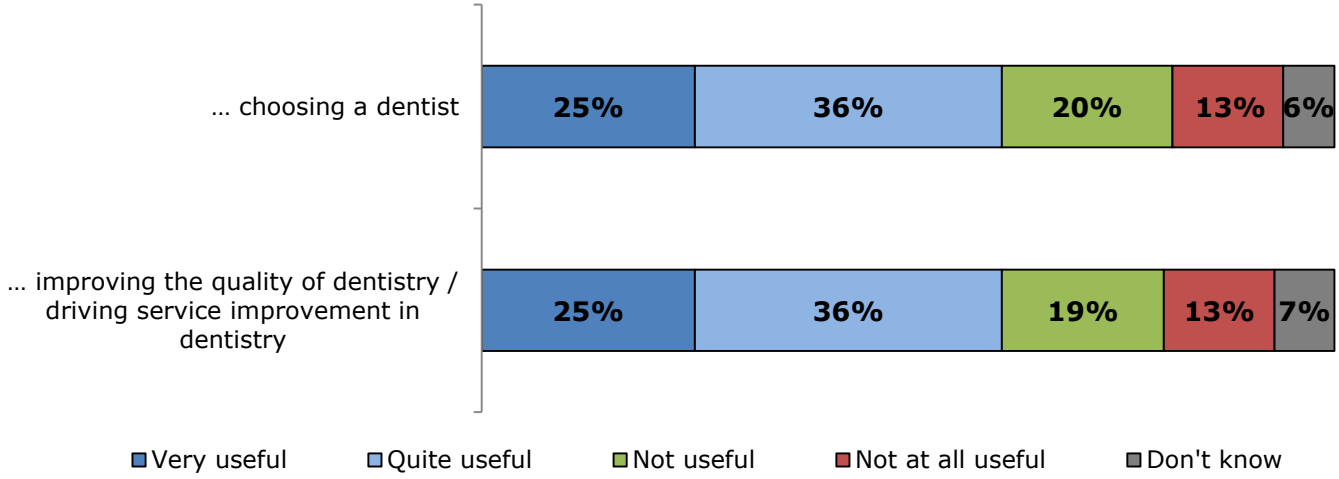
2.12 Using Feedback to Enhance Quality and Patient Choice

2.12.1 Star ratings

At the time of designing the survey, the government was discussing plans to introduce a star rating system for hospitals and doctors, and a question was included to explore how useful registrants thought that a star rating system would be when helping patients choose a dentist and to improve the quality of dentistry.

As shown below in **Figure 49**, very similar results were recorded for both choosing a dentist and improving the quality of dentistry, with a total of 61% indicating that a star rating system would be in some way useful for both these scenarios (25% very useful and 36% quite useful).

Figure 49 – Please indicate how useful the star rating system would be in…
Base: All respondents (3,611)



Significant differences in response to this question can be seen between registrant groups, particularly between dentists and DCP groups. As presented in **Table 14** below, dental nurses and technicians were much more likely to indicate that the star rating system would be useful when choosing a dentist (76% and 70% respectively) when compared with dentists and specialists who were more likely to suggest that it would not be useful (50% and 57% respectively). **Table 15** overleaf shows similar results when asking whether a star rating system would improve the quality of dentistry, with a greater proportion of dental nurses indicating that they thought it would be useful (74%) compared to much smaller proportions of dentists (43%) and specialists (37%).

Table 14 – Opinion of a star rating system when choosing a dentist by dental professional group

Choosing a dentist	Dental nurse	Dental technician	Dentist	Specialist
Useful	76%	70%	41%	34%
Not useful	19%	27%	50%	57%
Don’t know	5%	3%	9%	9%

Table 15 – Opinion of a star rating system to improve the quality of dentistry by dental professional group

Improving the quality of dentistry	Dental nurse	Dentist	Specialist
Useful	74%	43%	37%
Not useful	19%	48%	56%
Don't know	6%	9%	8%

This question was also asked in the GDC's Patient and Public Survey 2013, where 73% indicated that star ratings would be in some way useful when choosing where to go for dental care.

2.12.2 Other methods of recording feedback

Qualitative findings

Experience of recording patient feedback
Using feedback to enhance service quality and patient choice was explored further in the focus groups. Many participants had experience of receiving and recording feedback from patients, mainly in either the form of a patient satisfaction survey or via patient feedback forms. It was explained that their measures to record feedback in this way had been implemented either before or as a result of CQC inspections. Those who worked in an NHS setting also indicated that they routinely gather feedback as for them it is considered imperative to understand what they could do for their patients to make their experience better.

> *We have a comment box as part of CQC regulations. We go through it at staff meetings and implement it as much as we can.*
>
> (Dental nurse, focus group, Nottingham)

> *We do a survey. It shows the patients some love and that we listen to them.*
>
> (Dentist, focus group, Cardiff)

> *We do a questionnaire for virtually every patient.*
>
> (Dental nurse, focus group, Reading)

However, not all participants indicated that they collected patient feedback. A small proportion of dentists who worked in private practice indicated that they did not see much benefit from gathering patient feedback based on the belief that patients 'vote with their feet' and will simply not return if they are unhappy with the service and care they receive. Therefore, collecting feedback and acting on it was not something they gave much thought to.

> *General practice is different. They just don't come back, they vote with their feet. I don't gather feedback and I've been in practise for 32 years. It's never been part of my culture.*
>
> (Dentist, focus group, Glasgow)

> *If the waiting room is empty then you know you're doing something wrong.*
>
> (Dentist, focus group, Cardiff)

It appears that there is a split between those who felt that changes were made in their place of work as a result of collecting feedback, and those who did not see any changes and who indicated that they rarely heard what the feedback collected related to, positive

or negative. Some practices appeared to be very keen to collect feedback from patients and to openly discuss the feedback in staff meetings in order to drive service improvements, whereas others indicated that they were aware that feedback was collected but did not know of any changes that had been implemented as a result.

> *We put our patient comments in a monthly newsletter that gets emailed to patients so that they can read some real-life experiences…We put in positive stories to encourage people who have maybe had previous bad experiences.*
>
> (Dental nurse, focus group, Leeds)

> *We talk about the feedback that we get in staff meetings and then try and implement changes.*
>
> (Dental nurse, focus group, Nottingham)

> *The results get sent off somewhere and we don't hear anything else.*
>
> (Dental nurse, focus group, Nottingham)

The difficulties of patient feedback

It was clear from all five groups that recording feedback from patients was often quite difficult for dental professionals for various reasons. Firstly, it was widely felt that patient perception as to whether they had received good or bad dental care could vary drastically. What may have been a simple and painless procedure for one patient may have been a harrowing and painful procedure for another depending on their perceptions, their levels of experience of dental care and their expectations.

> *Patient feedback is a minefield. When you're delivering health care, it's often unpleasant…if you can't get through to them then they think they've had a bad experience…They go away and think they've been treated really badly when they haven't, they've been treated with as much care as anyone else.*
>
> (Dentist, focus group, Leeds)

> *It's all about the patient's perception of whether they've had a good experience or not. You may well have provided the best level of care possible, but they might have thought it was terrible.*
>
> (Dentist, focus group, Glasgow)

It was also felt that patients who provide feedback are generally those who think that they have had a bad experience and who are therefore more likely to leave negative reviews. Therefore, participants felt that patient feedback can often be very one-sided, with patients reporting their experiences but without providing important background information or context. The NHS Choices website was widely cited as the online location where patients typically left their feedback. It was also highlighted that, as a dental professional, it can be very hard to respond to negative patient feedback in a public domain such as NHS Choices due to issues of patient confidentiality. Participants who were dental practice owners explained that negative feedback online could be damaging for their business, as they felt that those looking for reviews and feedback online would often focus on the bad reviews, and that it often took a lot more positive reviews to outweigh a negative one, discouraging the public from visiting their practice.

> *You can give feedback on NHS Choices, but it just tends to be the people who've had a problem, not the people who've had a positive experience.*
>
> (Dental nurse, focus group, Nottingham)

> *Often people are going to write the negative and you don't get the five people to write the positive for that one negative. You do some really nice work and no-one*

says anything to you but the day you do something rubbish they're down on you like a ton of bricks.

(Dental nurse, focus group, Leeds)

Part of the problem is that patients put stuff in the public domain and you've got to be careful about confidentiality. And our business is depending on what they say.

(Dentist, focus group, Leeds)

Methods of obtaining feedback to improve patient choice and service quality

When discussing how feedback could be used to enhance service quality and patient choice in the future, one of the most popular suggestions was to implement a standard anonymous and randomised external patient survey at all dental workplaces. It was felt that this would collect results that would be more reliable than those collected directly by dental practices and other workplaces, as generally patients provide their feedback whilst at the practice and may therefore not provide responses that are a true reflection of their experience. Participants explained that implementing a randomised and anonymous survey would encourage more open and honest feedback in a neutral setting. It was also suggested that this survey could be administered by the GDC as part of their regulatory role.

It's got to be randomised and anonymous. That's the only way to get honest feedback. The GDC could contact a random sample of patients to ask them about their experience to get independent feedback.

(Dental nurse, focus group, Nottingham)

They used to contact a group of patients randomly and ask to take them somewhere and see them, unbeknownst to us, out of the premises, and they would get feedback from that patient about our care. I think something standardised like that might work.

(Dental nurse, focus group, Reading)

Some form of rating system was suggested, similar to the food hygiene rating present in restaurants and cafés, which could be implemented for dental practices based on the feedback they receive from inspections and satisfaction surveys. However, a large proportion of participants found the idea of rating systems to be unworkable due to the high turnover of staff at dental practices, meaning that it would be difficult to provide an accurate rating. Some participants mocked the idea of rating systems if they were suggested.

It could work if it was some kind of rating you could display. It's like when you go into a café or restaurant and they have the food and hygiene rating up. You see that and you think about it.

(Dental technician, focus group, Nottingham)

Places can have a very high turnover of staff so it wouldn't be fair to give a practice a rating based on different clinicians. But it would be hard to monitor people individually.

(Dental therapist, focus group, Nottingham)

Why don't we just have employee of the month?!

(Dental nurse, focus group, Glasgow)

Using patient experiences and patient stories was also suggested in the focus groups as a potential way of harnessing patient feedback to improve patient choice. This option was suggested by dental professionals who had experience of recording this type of

feedback which they had used for promotional materials such as newsletters and websites. However, it was accepted that this would only utilise positive feedback and would ignore any negative patient experiences.

> *We get quite a lot of patient feedback because patients [don't want to come to that particular practice because of the location], but when they do come it's a lovely centre, it's a nice new big building…and nine times out of ten they…don't want to go back to the referring place. We then ask those patients to send a patient story in, put it on NHS Choices and hopefully spread the word.*
>
> (Dental nurse, focus group, Leeds)

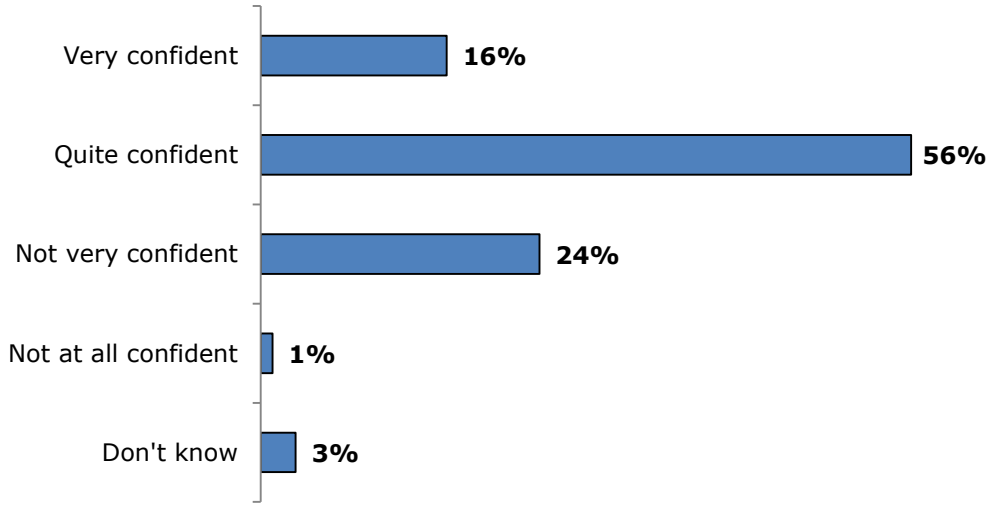
> *We put our patient comments in a monthly newsletter that gets emailed to patients so that they can read some real-life experiences…We put in positive stories to encourage people who have maybe had previous bad experiences.*
>
> (Dental nurse, focus group, Leeds)

2.13 Transition to Independent Practice

All dentists who had qualified in the last five years were asked to indicate how prepared they were for independent practice as a safe beginner upon qualification (a new question for the 2013 Annual Survey). As shown in **Figure 50** below, over half indicated that they were quite confident (56%), followed by a quarter who said that they were not very confident (24%). A further 16% indicated that they were very confident and just 1% that they were not at all confident.

The sample highlights that a larger proportion of dentists who had registered within the last two years (a total of 77%) said that they were more confident than those who had registered between 3 and 5 years ago (a total of 67%). A larger proportion of male respondents said that they were very confident at 22% compared to female respondents at 12%, whereas a larger proportion of female respondents said that they were not very confident at 29% compared to male respondents at 16%.

Figure 50 – On qualification, how prepared were you for independent practice as a safe beginner?
Base: All dentists who had registered in the last five years (571)



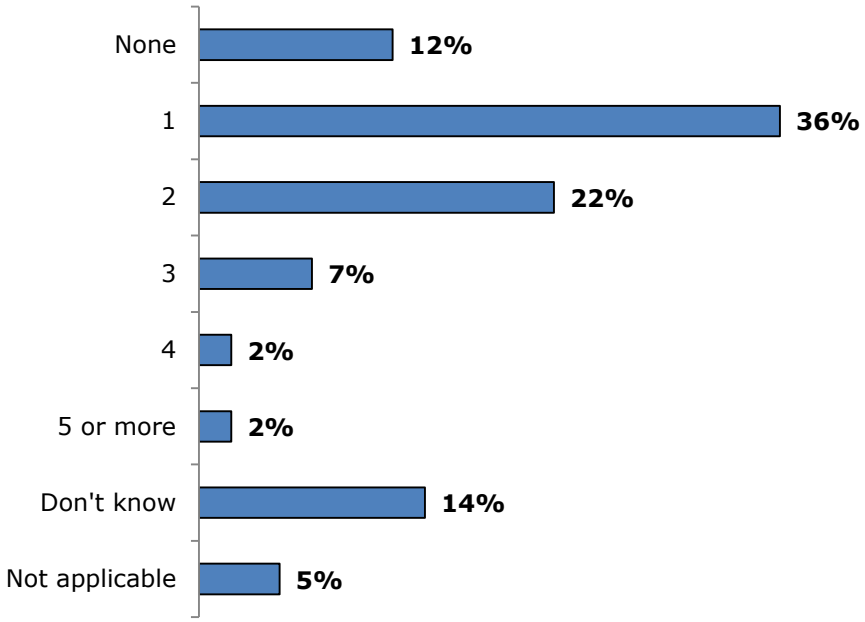
2.14 Workplace Inspections

The topic of workplace inspections was a new area covered in this year's Annual Survey of Registrants. All respondents were first asked to indicate how many external inspections their place of work has undergone in the past two years. As shown in **Figure 51** below, a total of 69% of respondents had undergone one or more external inspections in the past two years. The largest proportion (36%) indicated that they had undergone one inspection, 22% had undergone two inspections, and a further 11% had undergone three inspections or more. One in eight said that they had not experienced any inspections in the last two years (12%), and a further 19% said that they did not know how many their workplace had undergone or that inspections were not applicable to them.

Subgroup analysis of this question shows that a significantly larger proportion of respondents who worked in a dental laboratory said that their place of work had undergone no external inspections at 43% (compared to 12% overall). This percentage was also slightly higher for those who worked in the community/community dental services (16%).

The majority of those who worked as part of a dental practice said that they had undergone one external inspection at 42%, whereas a large proportion of those who worked in a hospital said that they did not know how many inspections there had been (25%). The sample also highlights that a larger proportion of respondents who lived in Wales had experienced no external inspections at 24% (compared to 12% overall).

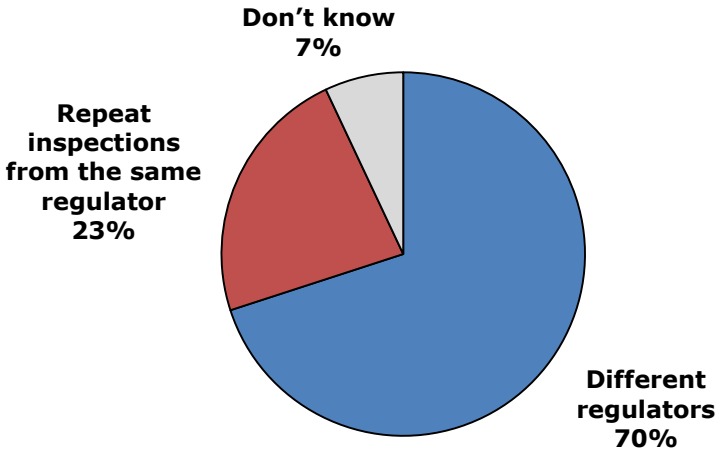
Figure 51 – Over the past two years, how many, if any, external inspections has your place of work undergone?
Base: All respondents (3,611)



Respondents who indicated that their place of work had undergone two or more external inspections in the last two years were then asked to state whether these inspections were from different regulators or repeat inspections from the same regulator. As shown in **Figure 52** overleaf, the majority of inspections were conducted by different regulators (70%), with a further 23% repeat inspections from the same regulator.

Respondents who lived in Wales and Northern Ireland were more likely to indicate that inspections were conducted by the same regulator at 44% and 72% respectively when compared with other areas. A larger proportion of respondents who provided private dental care only also said that inspections were conducted by the same regulator at 30% (compared to 23% overall). A larger proportion of dentists, however, said that the inspections their place of work had undergone were from different regulators at 77% (compared to 70% overall).

Figure 52 – Were these from different regulators or repeat inspections from the same regulator?
Base: Those who had experienced two or more inspections in the last two years (1,211)

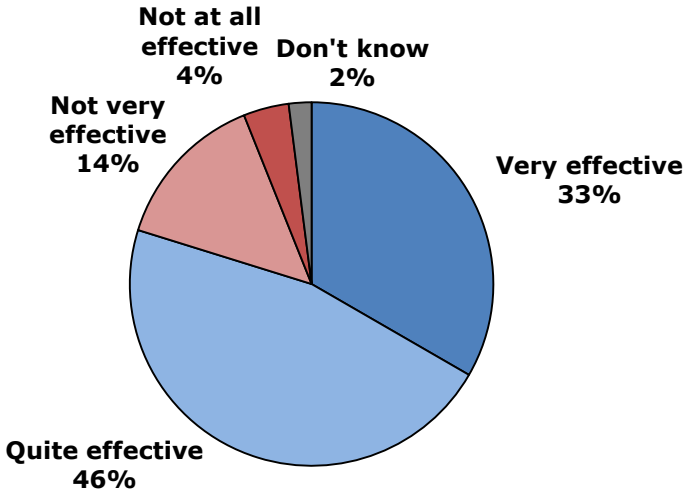


Finally, all those who indicated that their place of work had undergone one or more external inspection in the last two years were asked to state to what extent their believed the inspection(s) were effective in assessing the quality of their place of work. As shown in **Figure 53** overleaf, a total of 79% said that they thought the inspections were in some way effective, with 33% indicating that they were very effective and 46% that they were quite effective. Just 18% indicated that they believed inspections were in some way not effective, with 14% stating that they were not very effective and 4% that they were not at all effective.

Differences in response can be seen when looking at dental professional group, with a larger proportion of dentists and specialists stating that they believed inspections to be in some way not effective at 25% and 30% respectively (compared to 18% overall). This contrasts to dental hygienists, nurses and technicians, where a larger proportion stated that they believed the inspections were in some way effective at 82%, 85% and 82% respectively (compared to 79% overall). In terms of location, the sample highlights that respondents who lived in Scotland and Northern Ireland were more likely to believe inspections were in some way effective at 87% and 88% respectively.

A larger proportion of respondents who worked in the community/community dental services and in a dental laboratory also felt that inspections were in some way effective at 83% and 84% respectively.

Figure 53 – To what extent do you believe the inspection(s) were effective in assessing the quality of your place of work?
Base: Those who had undergone one or more inspection in the last two years (2,515)



Qualitative findings

Experience of and attitudes towards inspections
The topic of inspections was covered in the qualitative focus groups to further explore how registrants found external inspections and whether or not they found them to be effective. As seen in the survey results, almost all participants had experienced at least one external inspection in the past two years. The organisations who conducted these inspections varied between countries and included the Care Quality Commission (CQC) in England, the Healthcare Inspectorate Wales (HIW) in Wales, the Regulation and Quality Improvement Authority (RQIA) in Northern Ireland and the National Dental Advisory Committee (NDAC) and NHS Scotland in Scotland. A smaller number of participants also indicated that they had previously undergone PCT inspections and one participant who worked in an education setting indicated that they had undergone a programme inspection by the GDC.

In the main, participants were critical of CQC inspections, with common reasons why provided across each focus group. Firstly, it was felt that the CQC inspections did not focus on the most important areas that would impact on patient safety. It was explained that, based on their experiences, CQC inspections focused more on processes and paperwork rather than clinical procedure. This led participants to view CQC inspections as more of a box ticking exercise rather than a thorough clinical inspection of their practice and the way that they actually treat and care for patients.

> *We have CQC visits. They come along and look on top of a cupboard that's away from where everyone is being treated, run their finger along the top and find the tiniest speck of dust. And you can fail for that. That doesn't make sense to me. That doesn't affect patient care.*
>
> (Dentist, focus group, Leeds)

> *They weren't interested in whether staff were actually trained, they were just interested in whether someone had signed to say that they were trained. It's ticking boxes and anyone can tick a box.*
>
> (Dental nurse, focus group, Nottingham)

Another reason for dissatisfaction with CQC inspections, linked to the first, is the knowledge and experience of those conducting the inspections. Almost all participants who had undergone a CQC inspection explained that the inspector did not have a dental background and therefore did not have any expert knowledge about dentistry. They explained that they could not understand how someone without this knowledge could effectively inspect a dental workplace as they would not know what things to look out for and what things were right and wrong. They felt that this was the driving force behind CQC inspections feeling more like a box ticking exercise, as those conducting the inspections had no ability to correctly inspect the more important aspects of their workplace which would have a direct impact on patient safety.

> *It's bizarre that people who do the inspections aren't from the field. You need that knowledge to do it properly.*
>
> (Dental therapist, focus group, Nottingham)

> *The CQC have not got a clue about dental stuff.*
>
> (Dental nurse, focus group, Reading)

> *The CQC inspectors aren't always experts are they? How can you have an inspector who's not an expert inspecting something they know so little about?*
>
> (Dentist, focus group, Leeds)

Participants who worked in Scotland and Wales explained that their inspections were provided by other external regulators. However, it appears that attitudes towards these regulators were similar to those provided towards the CQC in England, with frustration at the professional background of inspectors and the focus on non-clinical aspects of their workplace such as paperwork. However, it should be highlighted that Scottish focus group participants in Glasgow explained that their new external inspections called 'Combined Practice Inspections' (introduced in January 2013) are an improvement on the previous system of inspections, despite participants explaining that these inspections they were now taking a similar approach to the CQC in England to practice inspections.

> *HIW inspections are mostly conducted by laypeople with no dental experience. They tend to pick up on non-clinical procedural issues like not scanning copies of paperwork.*
>
> (Dentist, focus group, Cardiff)

> *None of it has anything to do with clinical policy. They don't look at the quality of work. You could have a fantastic dentist but if he's not ticked all the boxes then he'll get penalised.*
>
> (Dentist, focus group, Glasgow)

> *There's a new practice inspection introduced in Scotland that is far more in depth than before. It's a combined inspection by the Scottish Dental Clinical Effectiveness Programme which is following in line with the CQC. I think it's a step in the right direction.*
>
> (Dental nurse, focus group, Glasgow)

A smaller proportion of participants indicated that they had experienced other types of workplace inspections from the PCT and from their employer if corporate such as Denplan. Feedback on these types of inspections tended to be much more positive in comparison to those undertaken by the CQC and HIW for example. These participants explained that the inspectors reviewed the more clinical aspects of their workplace as they had a better knowledge of dentistry, and could therefore offer them useful feedback.

They [Denplan inspections] *are sensible and not adversarial. Feedback is always on clinical improvement for the benefit of the patient.*

(Dentist, focus group, Cardiff)

We've had PCT inspections which we prefer. They're not necessarily of a higher standard but they're more relevant.

(Dental nurse, focus group, Nottingham)

The effectiveness of inspections

Despite generally low opinion of external inspections in terms of the knowledge and experience of inspectors and the areas focused on during inspections as a result, participants tended to view them as effective, in line with the results of the survey.

The main reason provided for this view was that external inspections kept dental professionals and workplaces 'on their toes', always striving to ensure that their workplace was complying with the relevant standards and regulations, as they knew that at very short notice they could be inspected. A number of participants also highlighted that external inspections did often make workplaces aware of certain aspects of their processes and procedures that they may have missed, ensuring that they are as up to date as possible with current regulations and requirements.

We're constantly prepared because we know they can come at any time and they can focus on anything.

(Dentists, focus group, Leeds)

Knowing that you can have a CQC inspection hopefully makes practices up their game. You can fall into a rut so you need to be prepared and in line with guidance.

(Hygienist, focus group, Leeds)

It keeps you up to date. Like we didn't know about the changes to CRB forms until we had a CQC inspection. They highlight areas like that.

(Dental nurse, focus group, Nottingham)

However, it was also suggested that inspections should be unannounced, with perhaps an hour's noticed similar to that used in the food industry, to ensure that practices are operating at the highest level at all times, not just when they know they are about to be inspected.

Don't give them that time to prepare so that once the inspection is done everything is forgotten about. It should be what you see is what you get.

(Hygienist, focus group, Scotland)

It was also suggested by a smaller number of focus group participants that inspections were also effective as some patients were aware that they took place, providing reassurance that dental workplaces are being inspected and are therefore operating to high standards.

I think if patients see that we're being inspected I think that is a positive boost in that they see we are actually doing what we are supposed to.

(Dental nurse, focus group, Reading)

It's reassuring for the public that someone's going out there to check and make sure these places are clean and hygienic and working properly.

(Dental hygienist, focus group, Nottingham)

It seems that, whilst the majority of participants were dissatisfied with the inspections for not focusing on the clinical aspects of their workplace, they still found the inspections to be effective as they encouraged them to make sure all aspects of their workplace were to the highest standard. Despite not really focusing on the clinical aspects of their workplace it ensured that they kept everything to the highest standard. However, it was highlighted that inspections would be even more effective if they were administered by someone experienced in the dental profession who know what to look for in terms of clinical procedures, as this would do more to improve levels of patient safety, rather than focusing on paperwork.

> *Some inspection is really effective when it's inspecting the right things, not how many cuddly toys you've got in your waiting room!*
>
> (Dentist, focus group, Leeds)

> *If it was someone from the relevant field who knew what they were looking for they would be a lot more effective.*
>
> (Dental technician, focus group, Nottingham)

2.15 Overseas Dental Professionals

The topical policy area of overseas dental professionals and cultural adaptation was covered this year's Annual Survey of Registrants. All respondents were provided with two statements about the training of dentists and dental care professionals who have qualified overseas and asked to state whether they were true or false.

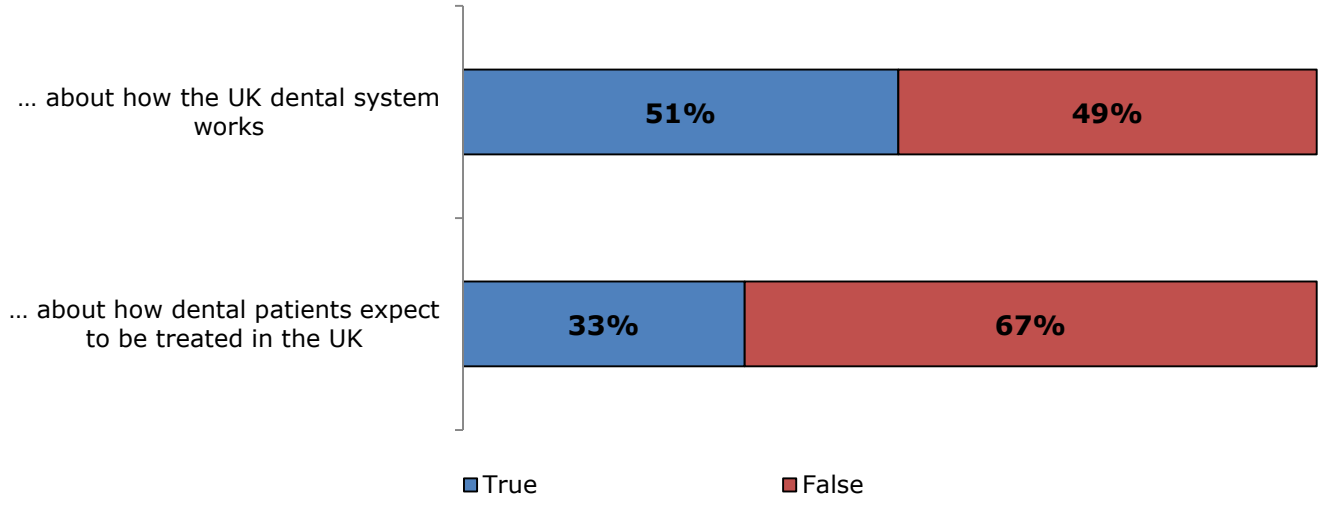
In answer to the statement that dentists and dental care professionals who have qualified overseas and practise in the UK receive training about how the UK dental system works, opinion was almost evenly divided between respondents who thought that it was true (51%) and those who thought it was false (49%).

Subgroup analysis of this result highlights that a significantly larger proportion of respondents of Asian/Asian British (57%) or Black/Black British (63%) ethnicity answered that this statement was true. In terms of registrant group, the sample also shows that a larger proportion of dental nurses answered that the statement was true (58%), particularly when compared to dental technicians (47%) and dentists (46%). A larger proportion of respondents who lived in Wales and Northern Ireland answered that the statement was false, both at 53%, compared to other areas.

In answer to the statement that dentists and dental care professionals who have qualified overseas and practise in the UK receive training about how dental patients expect to be treated in the UK, two thirds of respondents answered that it was false (67%).

Subgroup analysis of this result again highlights that a significantly larger proportion of respondents of Asian/Asian British (39%) or Black/Black British (58%) ethnicity answered that this statement was true. In terms of registrant group, the sample shows that a larger proportion of dental hygienists (73%), therapists (77%) and specialists (77%) answered that the statement was false. Also a larger proportion of respondents who lived in Scotland (72%) and Wales (73%) answered that the statement was false when compared to other areas.

Figure 54 – Dentists and dental care professionals who have qualified overseas and practise in the UK receive training…
Base: All respondents (3,611)



This question was also asked in the GDC's Patient and Public Survey 2013. Here, 62% of respondents answered that it was true that training was provided about how the UK

dental system works (+9%) and 52% answered that it was true that training was provided about how dental patients expect to be treated in the UK (+19%).

Qualitative findings

In depth interview participants were asked what they thought to the results of the survey in relation to overseas qualified dental professionals. The most common response from participants was that they themselves were unsure as to whether overseas qualified dental professionals received any kind of training for both how the UK dental system works and how patients expect to be treated in the UK, and that they expected that this would also be the case for the majority of registrants. However, when expressing this view, the majority of these participants indicated that they doubted that overseas qualified dental professionals received much in the way of training based on their experiences and from stories they had heard from colleagues, but that they were still unsure. It was suggested that this was the reason why the majority of survey respondents would have answered that training about how dental patients expect to be treated in the UK was not provided.

> *I'm not sure whether they do or they don't. From my experience of working in a hospital I know they were given guidance about how to deal with patients but I don't know if they had any proper training.*
>
> (Orthodontic therapist, depth interview, England)

> *I think most people genuinely won't know whether they do receive this kind of training or not.*
>
> (Dentist, depth interview, England)

> *I don't know if they do have training. From what I've heard perhaps they don't or there isn't enough training.*
>
> (Dental nurse, depth interview, Scotland)

A smaller number of participants were more aware of aspects of training that overseas dentists and DCPs received, which generally focused on the way the UK dental system works, but indicated that from what they knew the training was not comprehensive and they felt it did not prepare them for practising in the UK in both understanding of how the system works or what patients expect. It was also understood by a number of participants that those who came from a country within the European Union (EU) did not have to undergo the overseas registration examination which those who were from outside the EU were required to pass before being allowed to practise unsupervised dentistry in the UK.

> *I know for a fact they don't receive this kind of training, the system or what people expect. They just get told to read this and sign this piece of paper, then they start working. But they don't understand the dental system, it's far too complex to understand by reading something if English isn't your first language.*
>
> (Hygienist, depth interview, Scotland)

> *They have a week induction, a few days with another dentist to show them the systems, but that's it. So we as nurses have to do everything for them for the first year. It's hard work.*
>
> (Dental nurse, depth interview, Wales)

> *If you're not from an EEC* [EU] *state then you have to do training, but if you are from the EEC* [EU] *then you don't have to. You can walk straight into a practice and I think there's something wrong with that. There's no judgement of their competency. They should all have the same training.*
>
> (Dentist, depth interview, Northern Ireland)

In general, participants did not differentiate between the two types of training as they saw both as equally important. Many participants stated that it was essential to fully understand how the UK dental system works and also how patients expect to be treated in the UK, as they felt the UK was very unique in this sense and would not be the same in other areas of the world. It was, therefore, universally agreed by all participants that overseas qualified dentists and DCPs should undergo mandatory training in both these elements.

> *They should definitely receive training about this. I'm sure patient expectations will be really different in this country.*
>
> (Dentist, depth interview, England)

> *There's no question. Training like this should be mandatory. They need to learn about the attitudes of the public. I think some dentists can be very rude and not realise because that's just the way they can operate in their own country.*
>
> (Dentist, depth interview, Wales)

Based on their experiences, a number of participants explained that the standard of overseas qualified dental professionals could vary greatly. Based on a number of stories provided, it appears that participants found the levels of quality and understanding of those who were from a country within the EU were generally lower than those from elsewhere in the world as they were not required to undergo what they saw as sufficient levels of training.

> *I worked with a dentist who was from within the EU so had a quick crash course on how the NHS worked but he was clueless. His English was poor and his cultural attitudes were quite different. But then I worked with someone from Kosovo so they had to set the overseas registration exam and she chose to do foundation training to learn the NHS and she was fantastic.*
>
> (Dentist, depth interview, England)

It was therefore suggested in a number of interviews that all dental professionals should undergo various elements of training before being able to work in the UK, including a language test (which it was highlighted was already in operation), training about how the UK dental system works and what patients expect, and also some form of additional training to ensure that their knowledge and skills are equivalent to those who qualified in the UK. It was suggested by several participants that the GDC should take responsibility for regulating this type of training. It was suggested that this would benefit both the dental professional who would be able to provide a standard of care more appropriate to the UK, and also the patient who would feel more reassured that all dental professionals were qualified to the same standards whether they qualified in the UK or not.

> *You would need to know their qualifications are up to the same standards, something equivalent. The GDC should have to enforce this. It would be reassuring for patients.*
>
> (Dental nurse, depth interview, Northern Ireland)

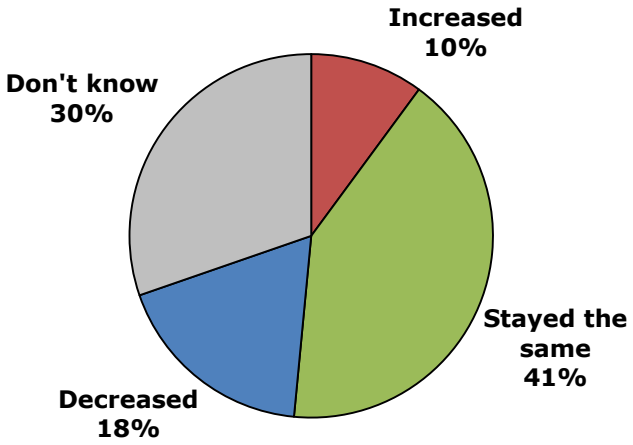
> *Even if they're from within the EU they should all do the overseas registration exam, a language test and then foundation training – it should be the same for everyone.*
>
> (Dentist, depth interview, England)

2.16 Complaints

The topical policy area of complaints was also specifically covered in this year's Annual Survey. All survey respondents were asked whether they thought that the number of complaints received by their place of work had increased, decreased or stayed the same over the last year. As shown in **Figure 55** below, two in five indicated that the number of complaints had stayed the same (41%). Just 10% said that the number of complaints at their work place had increased and a further 18% that the number had decreased. However, a significant proportion of respondents answered 'don't know' to this question (30%).

Dental technician respondents were more likely to answer 'don't know' to this question at 49%. A larger proportion of respondents who lived in Wales said that the number of complaints had decreased at 24%, whereas a larger proportion of respondents who lived in Northern Ireland answered that the number had stayed the same (50%).

Figure 55 – During the last year, do you think the number of complaints received by your work place(s) has…?
Base: All respondents (3,611)



Respondents were then asked to indicate how effective they thought their patient complaints procedure was in deciding which patient complaints should be investigated using their workplace complaints process and which should be referred to other organisations to investigate (for example, the NHS, the Parliamentary and Health Ombudsman, the Dental Complaints System, the GDC etc.).

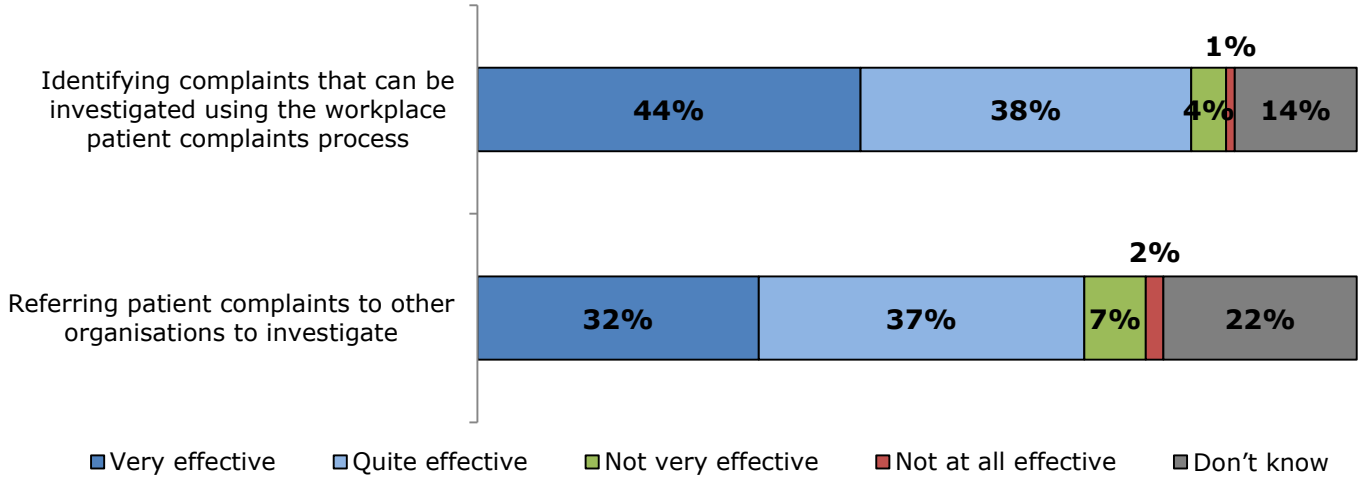
Figure 56 overleaf shows high levels of confidence expressed for both scenarios. Just over four in five respondents felt that their complaints procedure was in some way effective (a total of 82%), with 44% of stating that they thought they were very effective and 38% that they were quite effective, at identifying complaints that can be investigated using the workplace patient complaints process. In total just 5% indicated that they felt their complaints procedure was in some way not effective in this scenario.

A larger proportion of dental therapists indicated that their complaints procedure was effective in this scenario at 88% (compared to 82% overall), and the proportion of registrants who said that it was effective becomes greater as the number of years registered increases, from 73% for those registered for less than a year to 89% for those registered 21 years and over.

A smaller majority of 69% of respondents indicated that they thought their patient complaints procedure was in some way effective at referring patient complaints to other organisations to investigate (32% very effective and 37% quite effective). A slightly larger proportion of respondents said that they thought their procedure was in some way not effective in this scenario (9%).

When looking at where respondents lived in relation to this question, a larger proportion of respondents who lived in Northern Ireland said that they thought their patient complaints procedure was effective in this scenario at 77% (compared to 69% overall).

Figure 56 – How effective is your patient complaints procedure at…?
Base: All respondents (3,611)



2.17 The NHS Contract

A new NHS contract for dentistry was introduced in 2006 with the original intention to change the way in which dentists (or providers of dental care) were remunerated for NHS work, and to respond to changes in the needs of the population (namely improving oral health, more adults with their own teeth and an ageing population). However, like the contract it replaced, the current 2006 contract does not reward providers for actions taken to help prevent dental disease or encourage patients to improve their oral health. Instead providers are financially rewarded only for the activity carried out – e.g. for how many teeth are filled.

The proposed new NHS contract aims to succeed where the 2006 contract failed – by responding to the changes in the population (e.g. the fall in the number of people with tooth decay, the increase in the number of people retaining their own teeth and an ageing population) which have changed the needs of patients. The focus of the proposed new contract has shifted from treatment to prevention of disease and maintenance of good oral health.

The new NHS contract is currently being piloted in 90 areas across the country. The GDC is assessing the implications of the new contract for dental professionals and for dental regulation. In particular, the GDC is interested in understanding how the new contact could impact on registrant behaviour and standards. In order to contribute to the evidence base, the Annual Registrant Survey explored attitudes to and perceptions of the current contract and the pilots with dentists who took part in the qualitative research.

Views on the current contract
When discussing the current NHS contract, feedback from interview participants was universally critical based around the impact of the current system of Units of Dental Activity (UDAs), which they felt was detrimental to both patients and dental professionals in a number of ways.

Firstly, it was felt that the current UDA system did not enable dentists to provide the best treatment for their patients as it actively discouraged them from doing more complex work, as this would be done at a loss to the dentist and the practice. Participants explained that this either resulted in dentists simply providing the work at a loss, referring the work elsewhere, or encouraging some dentists to try and 'play the system' to ensure that they did not make a loss by splitting appointments.

> *Dentists effectively subsidise the NHS for certain treatment. Dentists make no money and often operate at a loss if doing NHS work. Or they have to play the system which doesn't focus on the patient as a result.*
>
> (Dentist, focus group, Cardiff)

> *We were getting a huge number of referrals from competent dental practitioners who were not doing straightforward procedures because there was no financial incentive for them to do so.*
>
> (Dentist, depth interview, Wales)

The second impact discussed was as a result of dentists potentially operating at a loss when providing certain types of dental care, which was the negative impact on patients. It was felt that as a result of the current system of UDAs, many dentists would simply not offer the correct standard of dental care if it involved any more complex (and more expensive) treatment, which would result in a poor standard of dental health for the patient. It was also indicated that some practices do not offer certain treatments once they have met their UDA caps or limits, and conversely that additional and unnecessary

treatment may be offered in order to meet UDA targets, meaning that patient care was worsened as a result.

This was referred to by many participants as 'supervised neglect', a term used to describe a situation where a patient's oral health has been allowed to deteriorate over a period of time, despite regular attendances to the dentist, which they felt was commonplace due to the current NHS contract.

> *I used to work in NHS and couldn't cope with it. You can't provide good dentistry in the current contract. You get the same reward for doing one filling as doing ten. I was encouraged to split treatments. It encourages supervised neglect and has only benefited people who know how to play the game.*
>
> (Dentist, depth interview, England)

> *It was a terrible idea right from the start. The fee system was totally confusing for patients and unfair for professionals. It discouraged dentists from doing any extra work and encouraged bad dentistry.*
>
> (Dentist, depth interview, England)

> *Some patients might not be offered certain treatments if we are over our UDAs. Similarly if there was a shortfall additional or further treatment might be offered.*
>
> (Dentist, focus group, Cardiff)

> *'Supervised neglect' is the term flying around and I would tend to agree.*
>
> (Dentist, depth interview, Wales)

The third negative impact of the current UDA system suggested by participants was that, as a result of there being no financial incentive to provide complex treatments and the pressures imposed on dentists to provide treatments at a potential loss, many dentists moved to providing only private dentistry where they felt they could provide a better standard of care and be financially rewarded for doing so proportionally and appropriately. A large number of dentist participants said that they felt the reason for the current problems with the NHS contract was that it was not properly piloted and that the views and concerns of dental professionals were not taken into account.

> *The contract pushed everyone into private work.*
>
> (Dentist, focus group, Cardiff)

> *The last contract wasn't piloted properly and when it was brought in people didn't like it and loads of people left the NHS.*
>
> (Dentist, depth interview, England)

It was, therefore, universally agreed by all dentist participants that it was time for a change to the current NHS contract which they saw as simply not fit for purpose as it did not work in the interests of patients or dental professionals.

> *The current contract rewards people for having bad teeth. It's not fit for purpose any more.*
>
> (Dentist, depth interview, Northern Ireland)

Views on the proposed contract

No dentists who took part in the qualitative research were currently participating in the pilot, but all were aware that it was taking place. Not all participants felt that they were able to comment on the pilot contract as they were only vaguely aware of it. It was, however, agreed that any changes to the current contract would be welcomed, and that moves towards more preventative dentistry were a step in the right direction.

Some participants, however, were more knowledgeable about the pilot contract and therefore were able to offer their perceptions of it. In terms of positive expectations, again it was widely perceived that a focus on prevention in dentistry was the right way forward. However a small number of participants caveated their feedback stating that the results of this change would not be visible for many years and, therefore, the profession should not expect to see instant changes as a result of focusing on this type of dentistry.

> *Preventative dentistry is a good step forward. People are changing their habits and are better educated about oral health. It's going to take time but over the next 50 years dentistry will change a lot in this country.*
>
> (Dentist, depth interview, England)

> *Preventative dentistry is very important. In the short term it will be a very slow process. People only think about dentistry if they get a tooth ache. It will be complicated but it's about changing attitudes of the public. A lot has changed in the last 50 years when people just wanted their teeth pulling out.*
>
> (Dentist, depth interview, Wales)

Participants highlighted that they thought the new NHS contract would benefit the patient as it would focus more on providing high levels of care by taking responsibility for the patients complete oral health based on their needs rather than simply 'drilling and filling'. It was felt that this would benefit patients who were interested in looking after their teeth, which participants indicated was becoming a more common attitude amongst their patients.

> *It will mean a move away from drill and fill as you should have more time for maintenance and oral hygiene.*
>
> (Dentist, depth interview, England)

> *It will create a more patient-oriented system and less 'drill and fill' which isn't right. If you have patients who want to look after their teeth they will stay on your books.*
>
> (Dentist, depth interview, Northern Ireland)

However, a significant proportion of interview participants indicated perceived concerns and potential drawbacks with the new NHS contract. A number of participants indicated that, whilst the move towards preventative dentistry was positive, it could mean that they would be required to spend a longer amount of time with each patient to cover everything such as oral health assessments, which could result in either fewer appointments each day or longer opening hours, but for the same financial reward.

> *I like the concept but not how they've gone about it. I like the focus on DCPs but they need to change how dentists are paid as we'll see less patients as each will take longer.*
>
> (Dentist, depth interview, England)

> *This is, as far as I can tell, effectively asking us to do more for less. It's not workable.*
>
> (Dentist, focus group, Cardiff)

> *There are a lot of potential problems with it. The Oral Health Assessments will take a long time so we won't be able to see as many patients.*
>
> (Dentist, depth interview, England)

Another potential drawback of the new NHS contract expressed by dentist participants was that it may move a lot of patient responsibility from dentists to who were perceived to be other less qualified DCP groups such as hygienists and therapists who are trained in providing preventative dentistry at a cheaper cost. It was felt by these participants that this may reduce the role of dentists in the future, as patients may become aware that they no longer have to see the dentists but can see a therapist for a lower cost.

> *I feel that less qualified staff will be given a greater role in health and nutritional advice and it will erode the status of a dentist. It'll be cheaper to employ less qualified people to do the preventative stuff so they'll do away with the dentist.*
>
> (Dentist, focus group, Cardiff)

> *A lot of dentists will be replaced by therapists as they're cheaper. You won't need as many dentists.*
>
> (Dentist, depth interview, England)

In general, the majority of feedback relating to the NHS contract was in favour of its ideas and concepts, but there were concerns and some participants were sceptical of how it would work in reality and what the consequences could be for the future of dentistry, particularly their own role as dentists. It was also highlighted that, as with the current contract, some dental professionals will eventually find a way to make the system work in their best interests and not necessarily the patient's.

> *The impact on patients will be the same as the previous contract. It will depend on who they see and where. If the dentist is focused on doing a good job then it won't matter, but you'll still find those who will work out how to make the most money out of it.*
>
> (Dentist, depth interview, England)

2.18 GDC Strategy and Priorities

All participants who took part in a focus group or a depth interview were asked to think about what the GDC's priorities should be when preparing its new strategy which sets the direction for the council for the coming years.

A variety of suggestions were made, many of which focused on issues and topics which had been discussed earlier in the focus groups or in depth interviews. Common suggestions are described below.

More support for dental professionals
As previously mentioned when discussing the GDC's role to protect the patient, by far the most common suggestion made by many qualitative research respondents was that they would like to see a more supportive role from the GDC for registrants. A widely held perception of participants was that the GDC was only interested in the views and concerns of patients and the public and were quite removed from dental professionals. Therefore, many participants saw the GDC as an unfriendly and unsupportive organisation who they would not think of going to for any advice or support, and who instead they often felt were 'out to get them'. It was felt that, if perceptions of the GDC changed, this could lead to a better working relationship between the GDC and dental professionals.

> *Go back to being about the dentists at the coal face in hospitals, practices and the community. They need to become more dentist friendly, not just patient friendly. I'd never go to the GDC at the moment, I'd go to the health authority or the protection society first. They'd be the last person I'd go to.*
>
> (Dentist, depth interview, Northern Ireland)

> *The GDC should be about protecting the patient through helping the profession. At the moment they are trying to protect the patient but they are not supporting us.*
>
> (Dentist, focus group, Glasgow)

It is important to highlight that all participants understood that the primary role of the GDC was to protect patients, and that other organisations were available to provide advice and support in the profession, but that many still felt that the organisation could do more to make themselves more approachable and supportive towards their registrants, taking a more positive approach to regulation. It was felt that the GDC would benefit from this change and was suggested that the GDC should focus on helping the dentist to help protect the patient rather than focusing on protecting patients from dental professionals, therefore having a more positive approach to the way that they interact with registrants.

> *Supporting dental professionals. Actually feeling that they're there for us and not just for patients. It just feels like they're all about the patient and we would like a bit of support and knowing that if we have a worry or concern we can get in touch with them and they could support us and back us up. You can call them up now but it's very impersonal and you just get the standard line. You don't feel like you're important to them at all.*
>
> (Dental technician, focus group, Nottingham)

> *A bit more support for the profession would be nice. Don't demonise us and have a bit more understanding. We're all afraid of them and it shouldn't be like that. We should be able to get help and advice from them if we need it. If I have an issue now I'd never go to the GDC.*
>
> (Dentist, depth interview, England)

Reviewing the Annual Retention Fee

Another common suggestion for the GDC's strategy was to review the Annual Retention Fee structure to take into account the various differences that exist within the registrant base. In particular, it was indicated by participants from all groups that the current structure was unfair for many registrants, especially dental nurses who were expected to pay the same amount as those who could be earning significantly more. Therefore, participants said that the specific groups within the DCP group should be taken into account based on their potential earning ability and their level of risk and clinical responsibility. It was also routinely suggested that the fee should take into account those who work part time hours, something which is commonplace for many DCPs.

> *They need to look at the ARF for nurses and make it proportionate.*
>
> (Orthodontic therapist, depth interview, England)

> *I think that they need to look at dental nurses as an independent group.*
>
> (Dental nurse, focus group, Reading)

> *The ARF clearly needs reassessing. You can't just have one flat fee for everyone.*
>
> (Hygienist, depth interview, Scotland)

It was also suggested that the GDC prioritise reviewing the way that the ARF is collected. A direct debit system was suggested by many participants including both dentists and DCPs to spread the cost of their registration, making it more manageable for them.

> *They definitely need to look at the cost – it's just too much and definitely look at bringing in direct debits so we can spread the cost.*
>
> (Dentist, depth interview, Scotland)

Dental nurse salaries

Linked to the views expressed concerning the ARF level for dental nurses, it was also widely suggested that the GDC should focus its efforts on improving the levels of pay for dental nurses. Participants from a wide variety of groups said that dental nurses were not fairly paid for the work that they do and the level of responsibility they have now that they are recognised by the GDC and the dental profession, particularly outside the NHS where there are no structured pay grades. A number of participants indicated that if rates of pay for dental nurses do not increase in line with increasing levels of responsibility, people will be deterred from entering the profession or will leave to work in another area where they can earn a higher salary with potentially less responsibility and regulation, and that this could have a damaging impact on dentistry as a whole.

> *There are a lot of girls out there who aren't getting paid what they should. It's great that we're now recognised as a profession but for many dental nurses nothing has changed and they aren't recognised for what they do. For a lot of them they now just have to pay to be registered and pay for their insurance.*
>
> (Dental nurse, depth interview, Wales)

> *It's annoying because you've got more and more student nurses that are qualifying, but when they don't get the pay rise then they just leave the profession.*
>
> (Dental nurse, focus group, Reading)

It was felt that, to truly recognise the role of dental nurses, pressure should be put on employers to ensure fair rates of pay are provided. Whilst this was a popular suggestion, particularly with dental nurse participants, it was also widely accepted that doing anything about this would be difficult as practice owners are trying to run a business and will not appreciate being told what to pay their staff. Although the GDC has no direct

responsibility for salary levels (something that was generally understood by participants), it was suggested that the GDC could develop guidelines or codes of good practice in order to encourage fairer salaries for dental nurses.

> *I understand that the GDC can't do anything to enforce wages, but they at least need to look at nurses' wages. Many earn less than a cleaner does. My kids laugh at me because they earn more than I do working in a bar. Without us the dentists cannot work so we deserve a fair wage for working hard.*
>
> (Dental nurse, depth interview, Wales)

> *There should be recommended amounts, banding systems like in hospitals, based on their qualifications and experience. That should all be recognised. But how would you do it? Dentists are running a business. It could be a code of good practice - that might help.*
>
> (Hygienist, depth interview, Wales)

Relocation of the GDC offices

The cost-effectiveness and spending of the GDC was often highlighted by participants when discussing the direction of the Council over coming years. Many participants felt that the GDC should look to save money where possible in order to become more efficient and to reduce the cost of regulation for registrants. The most common suggestion to achieve this was to relocate the GDC headquarters out of central London, which was perceived to be very expensive for housing GDC staff and also for conducing Fitness to Practise hearings. These participants explained that they could not see how the GDC justified its location in an expensive area of the country when they felt that it could be relocated to save a lot of money.

> *Stop being so London-centric. Why not move out of London, which is extremely expensive, to somewhere more central so that all parts of the UK can access it? They can bring their costs down that way and make it more fair access for the people who need to get there.*
>
> (Dentist, focus group, Leeds)

> *In this day and age it's ridiculous that they have central London offices on Wimpole Street. They could save a lot of money moving somewhere like Birmingham which is as easy to access. It would reduce hotel costs. It would make them more efficient at what they do.*
>
> (Hygienist, depth interview, Scotland)

Other participants were less focused on wanting the GDC to move out of London and were more focused on the addition of regional offices to increase the GDCs presence around the country. Many participants saw the GDC as a 'London-centric' organisation and felt that regional offices would help to increase registrant awareness of the GDC and improve relations between the GDC and its registrants. However, this opinion contradicts the attitude that the GDC is inefficient and spends too much money which was previously suggested.

> *They should consider regional offices so that we're more aware of them, where they are and what they actually do for us.*
>
> (Dental nurse, focus group, Nottingham)

> *Have a small presence in the North - several offices is a really good idea - and maybe one central one in a central location.*
>
> (Dentist, focus group, Leeds)

Further defining the scope of practice

Following on from feedback relating to Direct Access and the differing dental professional groups, another suggestion for a future priority of the GDC was to do more to further define the scope of practice in order to bring increased clarity for both dental professionals and the public. Firstly, it was expressed that the roles, responsibilities and services provided by each dental professional group should be made clearer, including information for registrants as to how they can progress into other areas if they want. It was explained that this was becoming increasingly necessary due to the overlapping of certain groups such as dentists and therapists. By also promoting the groups to the public this would help to improve patient awareness and allow patients to make more informed choices about their care.

> *Maybe they should clarify things and have more clarification of scope of practice. Clarify the roles of dental professionals, make it clear who does what, and how you can progress into other roles. The lines are becoming blurred.*
>
> (Dental nurse, focus group, Nottingham)

> *It's for the public and the professionals. People need to know that person can do that, that person can do that. Not have it woolly.*
>
> (Dental nurse, focus group, Nottingham)

It was also felt that increased clarity was needed within the GDC's standards about what all dental professional groups can and cannot do, particularly focusing on Direct Access which was seen to be too vague and non-specific.

> *They need to make the guidelines clearer for orthodontic therapists about what we legally can and can't do.*
>
> (Orthodontic therapist, depth interview, England)

> *They need to deal properly with Direct Access and make sure it is exactly what it says on the tin. Don't stop us from doing what we are trained to do. At the moment it's too on the fence.*
>
> (Hygienist, depth interview, Wales)

Other suggestions provided by just a few focus group or interview participants included:

- Reviewing the UDA system which was seen to be unworkable (although there was awareness that changes may be upcoming with the new NHS contract)
- Ensuring the quality of training and training providers
- Ensuring the quality of online training courses for CPD
- Ensuring dental nurses have a voice and are listened to
- Reviewing the status of clinical dental technicians within the GDC
- Focusing on the protection of the UK dental industry against overseas imports

2.19 GDC Standards Web Pages Review

The new Standards for the Dental Team document was published by the GDC and distributed to registrants in August 2013 and took effect on 30 September. The GDC is using the Annual Survey of Registrants to gather robust evidence about communication and awareness and use of the new standards by registrants. There are two strands to the research

- providing user testing and feedback about the standards for the dental team website
- following the dissemination and distribution of the standards, a survey to establish registrants awareness, use of the standards and preferences for communication.

In order to communicate and disseminate the standards, the GDC has developed an interactive website with case studies, scenarios and FAQs. At the time of the survey, the GDC was piloting this website and was keen to receive feedback from registrants about the page.

At the end of the questionnaire, all respondents were asked whether they would like to briefly look at one of four pages from the pilot website and answer three questions about it. In total, 33% of the sample opted in to review a web page (1,192 respondents). To ensure that all four pages of the pilot website were reviewed by a similar proportion of respondents, each respondent was randomly assigned a webpage to review. The four web pages are listed below, showing the number of respondents who reviewed them:

- Case studies (292 respondents)
- Frequently asked questions (268 respondents)
- Scenarios (304 respondents)
- Advertising checklist (328 respondents)

After spending a short amount of time reviewing their chosen page, respondents were asked three questions:

- How useful did you find this page?
- How easy to read / comprehensible did you find this page?
- How likely would you be to consult this page, if you were looking for guidance on the standards?

Figure 57 overleaf shows how useful respondents found each page. Similar proportions of respondents indicated that they found the page they visited in some way useful. In total, a slightly larger proportion of respondents stated that the frequently asked questions page was more useful at a total of 93% compared to the other pages. A larger proportion of respondents also stated that the frequently asked questions page was very useful at 43%.

Figure 57 – How useful did you find this page?
Base: Respondents who reviewed - Case studies (292) / Frequently asked questions (268) / Scenarios (304) / Advertising checklist (328)

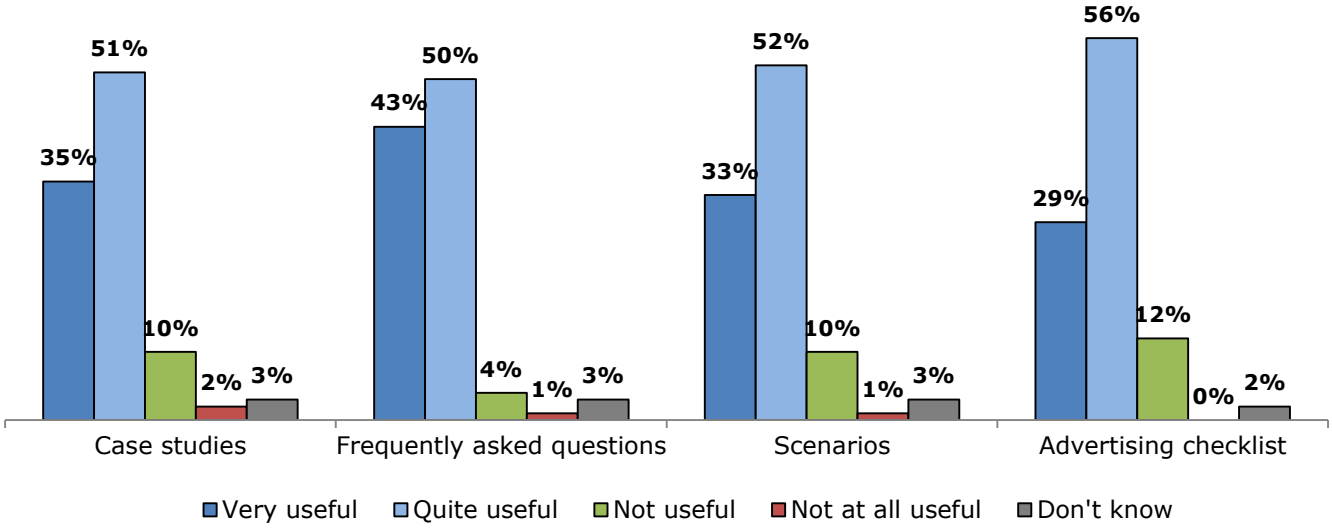


Figure 58 shows how easy to read / comprehensible respondents found each page. Again, similar results can be seen for each page, with almost the same proportion of respondents indicating that the page they viewed was in some way easy to read. Larger proportions of respondents indicated that the case studies (55%), frequently asked questions (53%) and advertising checklist (55%) pages were very easy to read when compared to the scenarios page (44%).

Figure 58 – How easy to read / comprehensible did you find this page?
Base: Respondents who reviewed - Case studies (292) / Frequently asked questions (268) / Scenarios (304) / Advertising checklist (328)

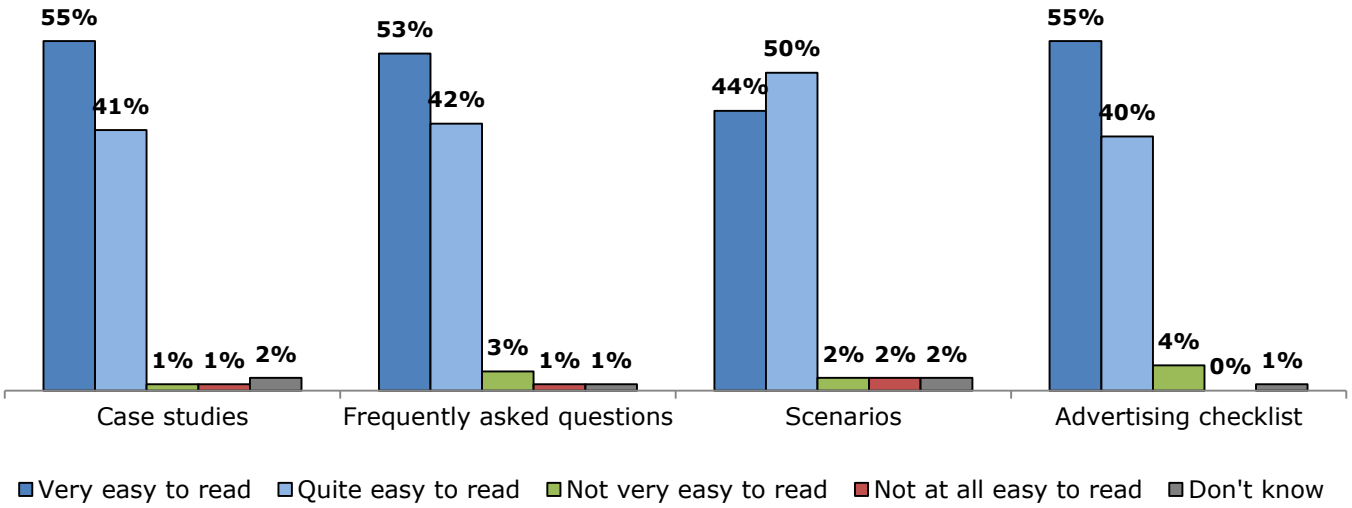
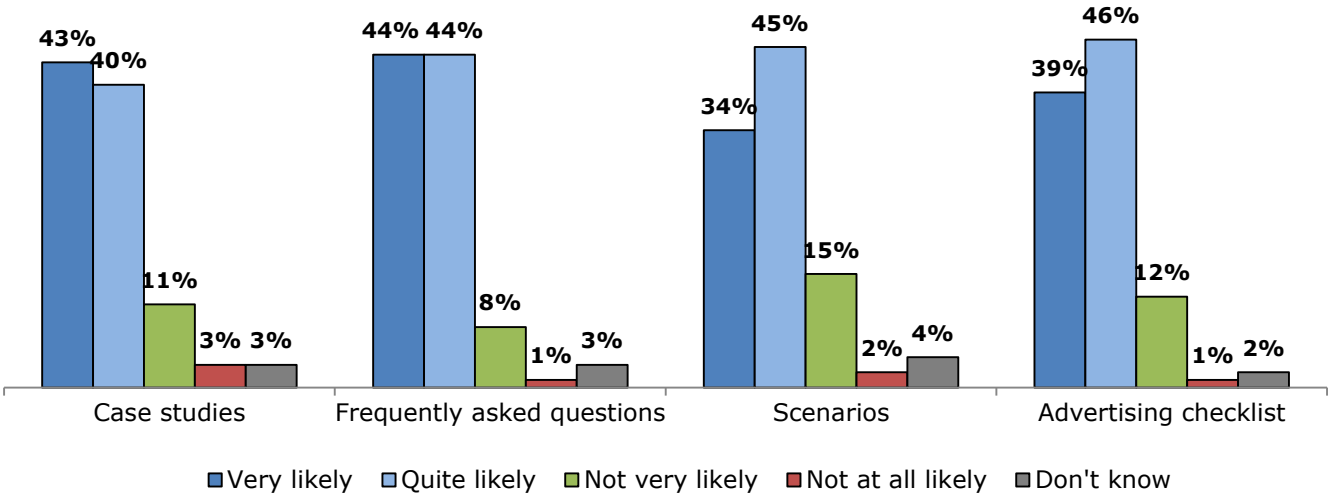


Figure 59 shows how likely respondents said they would be to consult the page they had viewed again if they were looking for guidance on the standards. A larger proportion of respondents who viewed the frequently asked questions page said that they would be in some way likely to consult this page again with a total of 88%, particularly compared to the scenarios page which recorded a total of 79%.

Figure 59 – How likely would you be to consult this page, if you were looking for guidance on the standards?
Base: Respondents who reviewed - Case studies (292) / Frequently asked questions (268) / Scenarios (304) / Advertising checklist (328)



The second stage of the research, involved testing the awareness and usage of the new Standards. In April 2014, six months after publication of the Standards, a bespoke survey will be sent to a stratified representative sample of registrants. The survey covers:

- awareness of the Standards
- how do registrants access the Standards?
- how often they refer to the Standards?
- why do they refer to Standards?
- which Standards did they consult?

The results of the survey will be available in April 2014 and used as evidence in the evaluation of the standards.

3. Conclusions

3.1 Views about the future and challenges

The results of this year's Annual Survey of Registrants have once again provided a useful insight into the current attitudes of GDC registrants towards the future of their profession. As seen in 2012, registrants are still split between those who are optimistic and those who are pessimistic about the future, but it is positive to note that this year a slightly larger proportion of registrants were optimistic.

Areas of optimism are almost identical to those found in 2012, and areas of pessimism are also similarly ranked but have generally decreased slightly in the proportion of respondents selecting them in 2013. Challenges in current daily practice have also been ranked in almost the same way as in 2012, but again have generally been selected by smaller proportions of respondents. These results may suggest a slightly more positive outlook for registrants.

3.2 Levels of regulation in dentistry

When comparing this year's online survey results to those collected in 2012, a number of positive shifts can be seen in terms of registrant attitudes towards regulation. For example, a slightly larger proportion of respondents felt that the current levels of regulation were 'about right' and smaller proportions of respondents suggested keeping up to date with changes in guidance, rules and law and meeting the demands of regulation were challenges in their daily practice.

However, the feedback collected in the qualitative research suggests that attitudes towards current levels of regulation are still very much split between those who see the levels as about right and those who see them as too much. Those who saw regulation as too much focused on the difficulties imposed by regulation on their daily activities and the difficulties provided by multiple organisations in addition to the GDC such as the CQC.

Despite attitudes towards regulation levels being mixed, it is encouraging to note that the majority of research participants were clear on the purpose of regulation to protect the patient and therefore saw it as an essential part of their profession. It can also be seen that many of the issues participants had with regulation were not necessarily related to the GDC but to other organisations such as the CQC.

It is therefore recommended that the GDC ensure that the benefits of any new regulations in relation to patient safety are made clear to dental professionals to ensure that they can see the purpose and benefits, in order to curb any frustration that those who see regulation as too much may feel. As was also recommended last year, it is recommended that the GDC increases its relationships with other regulating organisations and bodies to avoid any duplication of rules and regulations to prevent registrants feeling as though they are over-regulated on multiple fronts.

3.3 The reputation of the GDC

It is positive to note that awareness of the GDC and confidence in its role as a regulator were generally high. However, it is noteworthy that there has been a decrease in the proportion of survey respondents who strongly agree with statements about criteria which the GDC aspire to be (e.g. the GDC has a clear regulatory role, is trustworthy, is efficient etc.) and an increase in the proportions who neither agree nor disagree. This highlights that, whilst awareness of the GDC is high, perhaps the understanding of what the organisation actually does and how it operates is not as high, which may explain why

larger proportions of respondents felt unable to agree or disagree with statements about the GDC's reputation and behaviour.

The qualitative research findings back this up, where the majority of participants indicated that they had little or no experience of direct interaction with the GDC and therefore based their views and perceptions of the GDC on things that they had read or word of mouth from colleagues (e.g. when determining whether they felt the GDC acted in a fair and proportionate way). Therefore it is recommended that the GDC does more to promote its role, activities and actions to registrants so that they can have a better understanding of the organisation, perhaps changing perceptions as a result.

A common element of qualitative feedback in relation to the GDC's reputation was that they are not seen as an approachable or supportive organisation by registrants, and that the GDC is only concerned with the views of patients. It was strongly felt by many participants that the GDC could change the way it interacts with its registrants, even though they understood that its primary aim was to protect patients. It appears that a teamwork approach may be favoured, for example, helping dental professionals to protect patients rather than protecting patients from dental professionals, which appears to be the perception of a significant number of registrants.

3.4 The Annual Retention Fee

As seen in the 2012 annual survey, the majority of survey respondents and qualitative research participants indicated that the Annual Retention Fee was too high for DCPs, particularly for dental nurses. This view was expressed by a range of dental professional groups, including DCPs and dentists, based on the understanding that nurses tend to be on low wages and therefore see the £120 fee as substantial.

Opinion of the fee level of dentists was less clear cut, with a significant proportion of survey respondents stating that their fee level was too high, but many qualitative research participants explaining that if that cost was required to regulate the profession then that was what must be paid. Both dentists and DCPs often came to the conclusion that their fee level was too high due to knowledge of other professions and what they pay to be regulated, such as doctors, registered nurses and midwives, all of whom were perceived to pay less.

It is recommended that the GDC continues to review the principles on which the ARF is set, particularly for DCP groups, as it is widely accepted that the current structure of requiring all DCP groups to pay the same is unfair based on what can be very different earning abilities. The review should also take into account other factors such as hours worked, level of patient responsibility and risk, and could also look at how other organisations structure their fees to explore other potential options.

3.5 Communication

It is positive to see that, as in 2012, the majority of survey respondents felt that the GDC communicated with them effectively. Again, dental technicians were an exception to this finding, suggesting that they may require specifically tailored communication or further investigation as to why they are more likely to be dissatisfied with communication from the GDC.

This year's results show a significant increase in the proportion of survey respondents using online communication channels to find out information about the GDC including the GDC Gazette online, the GDC monthly e-newsletter and the GDC website, and a decline in the proportion finding out information via the GDC Gazette by post. This shows that recent moves towards focusing on online communication channels are having an impact.

It is likely that if this trend continues, in the coming years the usage of the GDC Gazette online will reach similar levels of the GDC Gazette by post in previous years.

3.6 Written CPD plans

The majority of survey respondents stated that they did not have a written plan of the CPD they intended to carry out in the next year, and feedback from the qualitative research on this topic was generally critical, with participants highlighting the practical difficulties and questioning the benefits of a written plan for the majority of dental professionals.

If written CPD plans are to become a requirement for all registrants, it is recommended that the GDC makes the benefits as clear as possible to avoid it being seen as a chore by registrants or simply ignored as they struggle to see the purpose. The GDC should also review any practicalities raised such as the difficulties of sticking to a plan and scheduling training courses months in advance.

3.7 Direct Access

Now that Direct Access is a valid option for many DCP registrants, survey results show that DCPs are less likely to indicate that they will take up the option than they were in 2012, when the option of Direct Access was not yet confirmed as a possibility. Feedback from the qualitative research goes some way to explaining this result, where participants explained that the idea of Direct Access was good, but that there were various barriers in place that would deter or prevent DCPs from taking up the option. These included the definition and scope of Direct Access within the GDC's standards, the confidence levels of DCPs, the lack of training and upgrading of knowledge and skills and low levels of awareness.

It is therefore recommended that, if the GDC want to see Direct Access be taken up as an option by a greater number of DCPs, more is done to increase the confidence levels of DCPs to do so. This could include making the guidance on Direct Access clearer to avoid any misinterpretation or vagueness and to highlight training opportunities for DCP respondents who may be interested in taking up the option but who do not feel confident enough in their current abilities to do so.

3.8 Raising concerns

It is encouraging to note that confidence levels expressed in the survey in relation to raising concerns were high, including knowing where to go, feeling that the workplace was a place where concerns could be raised openly and would be listened to, and knowing how to raise a concern as a result of education or training.

In both the survey findings and the qualitative research feedback it can be seen that registrants would much prefer to raise a concern at their place of work and view the GDC as a last resort in this situation, or as the appropriate place to raise a major concern. A small number of participants indicated that they had had bad experiences of raising concerns, and it was discussed that whistleblowing can be difficult, particularly for those in less senior positions such as dental nurses, which stands against the high levels of confidence found in the survey results. This is perhaps an area that the GDC could investigate further to explore exactly how all registrants find the process of raising concerns.

3.9 Using feedback to enhance quality and patient choice

Whilst star ratings are no longer being considered as a way of enhancing quality and patience choice, it is interesting to note that the majority of participants felt that they would be useful in some way when helping patients choose a dentist and to improve levels of quality. This shows that a significant proportion of registrants may be open to this kind of feedback system and that similar options could be explored with this in mind.

Qualitative research feedback highlighted that dental professionals found the area of patient feedback difficult, and therefore the suggestion of an externally administered randomised and anonymous survey may be a way forward as it would remove this from the hands of the professional and could potentially record more accurate and useful feedback.

3.10 Workplace inspections

The research shows that most dental professionals are accustomed to external workplace inspections from multiple regulators. It is evident that there is significant dissatisfaction with certain inspections, particularly those administered by the CQC, who are seen to be lacking in specific knowledge and experience of dentistry and who focused more on paperwork and less on important clinical procedures.

However, it is interesting to see that despite their low opinion of some of the organisations which carry out the workplace inspections, the majority of survey respondents and qualitative research participants felt that inspections were effective in some way. Should the GDC focus on attempting to ensure external inspections are conducted by inspectors with knowledge of dentistry, it could be assumed that registrants would view the inspections as even more effective.

3.11 Cultural adaptation

The research findings have shown that perceptions of whether overseas dental professionals receive any kind of training are unclear. Many qualitative research participants indicated that they were vaguely aware of the training they received, or simply did not know. However, it was universally agreed that training should be mandatory for all those who wish to practise in the UK, whether they are from outside the EU or not, in order to ensure that all dental professionals in the UK are working to the same standards. Therefore it is recommended that the GDC make it clear to registrants what training is provided to overseas qualified dental professionals and also that the possibility of further mandatory training is investigated.

3.12 The NHS contract

Qualitative feedback from dentists shows that there is a strong perception that it is time for a change in terms of the NHS dental contract, with general dissatisfaction expressed in relation to the current contract, particularly the current system of UDAs.

The focus and ideas behind the new NHS contract are seen to be moving in the right direction, with the focus on preventative dentistry seen as a positive move. However, those who were aware of some of the specifics of the new contract had a number of concerns, such as the time it would take for an average appointment and the move from dentists to other roles such as therapists. It is therefore recommended that dentists are given the opportunity to have their say on the new dental contract in some way before it is confirmed in order to ensure that any concerns and issues can be raised.