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GDC 'Raising Concerns' Research

Final Research Report

February 2015

Disclaimer:

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Contents

1. Executive Summary

The overall aim of this research project was to gain an in-depth understanding of the circumstances leading General Dental Council registrants to decide whether to raise a concern or not. A qualitative approach was used in order to explore the perceptions of a range of registrants in-depth. The research took place between October and December 2014. Previous research by the Professional Standards Authority[1] had examined how professional regulation might encourage health professionals and social workers to be more candid when things have gone wrong, but this work had not been specific to the dental profession. In addition the GDC's own Annual Registrant's survey[2] of April 2014 had included a section about raising concerns which highlighted some important findings that required further exploration.

Key Findings:

- Most respondents are aware of the existence of the GDC's new standards. However, awareness of the detailed content of the standards, including the duty to raise concerns, is more variable.
- It is widely acknowledged that there are grey areas and that it can be very difficult to judge whether something constitutes a concern or not.
- The research has identified a large number of barriers to raising concerns. These barriers fall into four key categories:
    - Broad cultural and systemic barriers (e.g. no overall culture of raising concerns; poor practice becoming normalised.)
    - Workplace barriers (e.g. differences in terms of culture, setting, size and nature of the workplace.)
    - Personal barriers (e.g. lack of confidence; fears about the personal impact of raising a concern; loyalty to colleagues.)
    - Process barriers (e.g. some uncertainties about the process; lack of access to impartial advice and lack of anonymity.)
- Registrants describe weighing up whether to raise a concern or not. The benefits are weighed against the risks/disadvantages of doing so. Some, however, simply try to avoid or work around the situation, rather than raise a concern.
- A number of specific barriers exist with regard to raising concerns with the GDC (or another relevant regulator) directly. Predominantly there is some negativity and mistrust towards the regulator and a feeling that involving the regulator will be stressful for the person raising a concern and unfair or too punitive.
- Many of the triggers and enablers that might encourage registrants to raise concerns represent the removal of, or are directly opposite to, the

[1] "Learning from academic research to support advice to the Secretary of State," October 2013 – Professional Standards Authority.
[2] Standards Awareness Survey April 2014, conducted on behalf of GDC by Enventure

barriers identified. In addition, an individual sense of ethical or professional duty is a major prompt for raising concerns.

- When asked to suggest how registrants could be further encouraged to raise concerns. The most common suggestion was the introduction of an anonymous helpline to provide initial guidance on whether the concern should be formally raised or not.
- Other solutions centred on changing negative workplace cultures; more training or more guidance in various forms and the development of more support networks and peer to peer review mechanisms.

2. Background, Objectives and Methodology

2.1 Background

The General Dental Council (GDC) is committed to using research to build an evidence base to inform the organisation's policy and practice. This is underpinned by the GDC's 2010-14 Corporate Strategy which adopts evidence-based policy as a corporate value, stating that "policy *is developed on the basis of consultation and evidence*."

"GDC Standards for the Dental Team", published in 2013, include nine principles including that dental professionals must adhere to at all times. The standards include the principle to 'raise concerns if patients are at risk'. This applies whether the concerns relate to dental care, or general protection of patients, particularly vulnerable patients. The GDC defines raising a concern as being '*when a dental professional speaks up about something that they think could be putting others at risk. In the dental team, you would probably be speaking up about something which is posing a risk to patients, but it could also be something which is posing a risk to colleagues. Raising a concern is different to making a complaint. When you raise a concern, you are reporting something you have witnessed*.'[3]

The GDC's Standards for the Dental Team set out the standards of conduct, performance and ethics that apply to all dental professionals. The standards state that:

- Registrants must raise any concern that patients might be at risk due to:
  - The health, behaviour or professional performance of a colleague;
  - Any aspect of the environment where treatment is provided; or
  - Someone asking them to do something that they think conflicts with their duties to put patients' interests first and act to protect them.
- They must raise a concern even if they are not in a position to control or influence their working environment.
- Their duty to raise concerns overrides any personal and professional loyalties or concerns they might have (for example, seeming disloyal or being treated differently by their colleagues or managers.)

The GDC is commissioning this research as part of its response to the 'Report into the Mid Staffordshire NHS Foundation Trust Public Inquiry' (the Francis Report). One objective of the GDC's action plan in response to the Francis report is to review how it deals with registrants who raise concerns, to ensure that there is no perception that the GDC will treat such actions by its registrants as a

[3] http://www.gdc-uk.org/Dentalprofessionals/Fitnesstopractise/Pages/Advice-on-raising-concerns.aspx

fitness to practise issue (i.e. that if a registrant does raise a concern about another registrant, doing so will not in itself mean that the first registrant somehow finds him or herself in trouble with the regulator, or is disadvantaged in some other way.)

The GDC appreciates that taking the decision to raise a concern in the workplace is often a difficult one, which may impact on registrants' personal and professional lives. The GDC therefore needs to help to create the right environment, and provide appropriate help and advice so that registrants feel able to raise concerns through the correct channels, and can be confident that they will not pay heavily for their actions. To do this, the GDC needs to:

- identify the barriers which affect registrants who want to raise concerns, and the enablers which will help them do so;
- provide clear guidance/advice for registrants who may want to raise a concern, taking into account the identified barriers and enablers;
- ensure that the GDC's internal processes enable them to deal effectively and efficiently with registrants when they raise concerns, taking into account the identified barriers and enablers.

Previous research by the Professional Standards Authority had examined how professional regulation might encourage health professionals and social workers to be more candid when things have gone wrong, but this work had not been specific to the dental profession. The GDC's own Annual Registrant's Survey of 2013 had included a section about raising concerns which highlighted some important findings that required further exploration.

2.2 Research objectives

The GDC commissioned a programme of research in order to gain an in-depth understanding of the circumstances leading registrants to decide to raise a concern. The specific research objectives cover three broad areas:

Area	Objectives
Understanding and awareness of what a 'concern' is and expected courses of action	• Identifying and understanding the issues which lead registrants to raise concerns. • Understanding how they decide what constitutes a concern that should be raised. • Identifying expectations, hopes and concerns for the process.
Barriers and enablers	• Identifying and unpicking the factors which encourage or discourage registrants from raising a concern, including their relative weight and influence. • Identifying and exploring barriers and enablers within the 'raising a concern' process/es which may encourage or discourage the professional
Individuals' experiences	• Understanding the process from the perspective of the informing/ potentially informing professional.

2.3 Methodology

A qualitative approach was used in order to explore the perceptions of a range of registrants in-depth and provide the necessary level of insight.

2.3.1 Phase One: telephone interviews

Telephone interviews were conducted with registrants who are currently practising as dentists or dental care professionals (DCPs).
Respondents were recruited from two sources:

- Respondents to the GDC's Annual Survey of Registrants 2013. The survey included a question that asked respondents whether they would be interested in taking part in future research carried out by or for the GDC.
- Registrants who have previously expressed a concern to the GDC.

Respondents to the GDC's Annual Survey of Registrants, who had indicated that they were willing to be re-contacted, were emailed a link to an online screening survey which asked questions relating to key demographic and professional information and whether they had previous experience of raising a concern. Potential respondents were then selected in order to meet agreed behavioural (i.e. whether they have previously raised a concern or considered raising a concern) and demographic quotas. An appointment for a telephone interview was scheduled with those respondents selected for interview. In total 32 interviews were conducted with registrants from this data source.

These interviews were then supplemented with four interviews conducted with registrants who had previously raised a concern with the GDC. This source was used in order to ensure that some registrants with experience of raising a concern directly to the GDC were included in the research.

In total, 36 telephone interviews were conducted between 20th October and 20th November 2014. The respondent profile is provided in Appendix A.

As is commonly required to aid successful recruitment for such research, respondents were offered an incentive payment of £50 in the form of a personal cheque or a donation to a charity of their choice, in order to acknowledge their contribution to the research.

All interviews were conducted by one of four senior researchers. Interviews followed a semi-structured discussion guide; a copy of which is provided in Appendix B. As part of the interview, hypothetical scenarios were referred to in order to stimulate discussion and debate. These are also provided in Appendix B.

All interviews were audio recorded and transcribed to facilitate analysis.

2.3.2 Phase Two: online bulletin board

A second phase of research, an online discussion forum which built on the findings of the first phase, ran from the middle of November to the first week of December 2014. The GDC was keen to have some form of group discussion amongst registrants in order to stimulate ideas and to give them an opportunity to debate issues emerging from the first phase of research.

Those who participated in the first phase of research were asked to continue their participation in the debate via an online bulletin board. Respondents were asked to log in and out of the bulletin board (at times of their choosing) on several occasions over the period of its operation.

The online debating space was set up using MRQual software (http://mrqual.com/).

Community Research designed a series of questions and prompts used during the bulletin board process. As well as answering questions posted by the Community Research moderator, respondents in the online forum were able to view each other's comments and make further comments in response. Selected GDC staff were able to log in and out of the bulletin board discussions as they progressed and observe the developing dialogue.

In total 28 respondents logged into the online forum, although two of these respondents contributed very little and were therefore not, in the end, paid an incentive for this phase of the research. The remaining 26 respondents were given an incentive payment of £50 (again a personal cheque or charity donation) for their contribution to this phase of research).

The findings of the depth interviews and the online bulletin board have been written up thematically rather than reporting on each research phase separately.

3. Understanding and Awareness

3.1 Awareness of the duty to raise concerns

Most respondents indicated that they are aware of the existence of the GDC's new standards. This supports the findings of the GDC's recent quantitative research[4] which indicated that, of those registrants who were aware of the GDC standards, the vast majority of registrants (93%) were also aware of the new standards.

However, awareness of the detail of the content of the standards appears more variable. A small number of respondents explicitly mentioned the duty to raise concerns (as outlined in the GDC standards) and the need to 'protect' themselves or colleagues as a driver of raising concerns.

> *"I try and put it across like a self-protection issue and say to them it's not something that you want to do, however, you've got to do it because this could be a piece of a jigsaw, that there's a catalogue or there's several pieces of a jigsaw going on here, so you've got to, no matter how small you actually think it is." (Female dental nurse, hospital setting, qualified between 2-5 years, White British, Scotland)*

However, some respondents (including both dentists and DCPs) indicated that they are not at all familiar with the standards, including the duty of registrants to report concerns.

Respondents appear to be more aware of the duty to report concerns if:

- They are working in a role which involves responsibility for training.
- They are working in hospital or community settings, where it is apparent that there has been a recent focus on safeguarding training.
- Those who take a proactive interest in their own development and ensure that they keep up-to-date with issues.

> *"But, obviously, being a professional person you kind of know what's right and what's wrong but also, if you're keeping up with your CPD and things you kind of know the guidelines, if you read them properly you know what's expected of you. And it is part of being a dental professional, so you kind of know what's right and what's wrong and it is appropriateness of certain things of what to do and what not to do. You're kind of trained really in many ways, I think it's a bit of everything." (Female dental nurse, hospital setting, between 5-10 years, White British, England)*

[4] Standards Awareness Survey April 2014, conducted on behalf of GDC by Enventure.

- They are recently qualified[5]:

  "I think it was definitely from university. We had a lot of discussions about raising concerns and what would you do?... Then I think it's been drilled in that you need to act safely and do what you think is right so you can sleep with a clear mind basically". (Female dentist, working in a dental practice, qualified less than 2 years, Asian/British Asian, England)

  "We actually had lectures from the GDC as well and the whole way through we were getting taught professionalism and how to look after yourself but look after your patients first of all." (Male dentist, dental practice, qualified less than 2 years, White British, Scotland)

  "I would say my knowledge about making complaints and concerns has come from doing my degree in primary dental care, because we focussed a lot on the standards of dental care and we looked a lot at raising complaints and the issues surrounding it. Before I did the degree, I probably would have worked happily in practice not really knowing what I should do if I had a complaint. [Are you aware of any mentions of raising concerns in the new GDC standards?] Yes, I think there's a whole section on raising concerns. I did read them actually. I did a lecture on the standards so I do know them." (Female dental hygienist, dental practice, qualified between 10-20 years, White British, England)

It is interesting to note that those who are recently qualified appear to have higher levels of awareness of the duty to raise concerns than those who have been qualified for longer; but they are also the group who appear to have the highest number of barriers in terms of raising concerns. This point is explored further in Section 4.3.1.

Those who have been qualified for a longer period were very often aware that they should raise concerns because it is 'common sense', rather than through a conscious or precise knowledge of The GDC's standards. There was a sense that good and experienced dental professionals know right from wrong and that their professional conscience informs them of the necessity of raising concerns.

It was evident that some respondents who had been qualified for 20 years or over were less familiar with the detail of the standards. When questioned about their knowledge of the duty to raise concerns, they tended to be a little evasive about their knowledge, instead referring to their years of experience and the fact

[5] The Annual Registrant Survey 2013 indicated that 57% of those registered with the GDC within the last 5 years said that raising concerns was featured in their education course. This increased to 69% of those registered less than 1 year and 68% of those registered 1-2 years.

that they feel that they just know what is 'right or wrong' without having to refer to the standards.

"[Where does your understanding come from?] Common sense, I've been graduated since 1975 so I've seen a few things." (Male dentist, community setting, qualified more than 20 years, White British, England)

"The General Dental [Council] Standards are obviously important, but when somebody is doing something wrong it's pretty obvious, you don't need to look in the book for it, do you really, that much?" (Male dentist, community setting, qualified more than 20 years, White British, England)

If respondents were aware of the duty to raise concerns in the standards, they were asked for a little more detail on their source of information. A range of sources were mentioned including:

- Recent training from their defence organisation on the standards.

  "I went to a thing last year by the Dental Defence Union about the GDC standards, it went through all the bits, so that has brought it to the forefront of my mind. But also it has brought it to the front of my mind because of issues we were having at work..." (Female dentist, community setting, qualified more than 20 years, Black African/Caribbean/Black British, England)

- Emails or a copy of the revised Standards booklets from the GDC
- Coverage in recent continuous professional development (CPD) activities that they have undertaken.

  "Obviously the GDC and the standards, and also I do a lot of continuing professional development, I make sure I'm fully up to date with what policies and procedures and guidance are available and recommended. And also the corporate company I worked for, it was the one before my last job, so my job before I worked here was a fantastic practice and I was there for a long time. I think I took a lot from that as well, they were very open with all their policies and procedures and they made sure everyone fully understood the job role." (Female dental nurse, dental practice, between 5-10 years, White British, England)

- In-house training at their workplace or it being brought to their attention at staff meetings.

  "[When you looked at them, did you notice that there are some obligations to raise concerns in the new standards?] Well, it was all brought to our attention that we have to read them and we have to look through them. So, yes, at the time I did, I've got the booklet downstairs and I can get it and read

through now." (Female dental nurse, hospital setting, between 5-10 years, White British, England)

Some respondents raised concerns about the levels of awareness of others. For example, some voiced concerns that non-clinical practice managers or owners are not aware of registrants' duty to raise issues.

"I think it's something that should really be encouraged for all practice managers about how to handle difficult situations like that …. to raise a concern like that." (Female dental hygienist, dental practice, qualified more than 20 years, White British, England)

3.1.1 'Raising concerns' rising up the agenda

Some respondents spontaneously mentioned that they feel that raising concerns is now **higher on the agenda** than was the case a few years ago.

"Within special care itself I think the attitude [to raising concerns] has changed a lot in the last five years, so in a lot of things the practices have changed in the last five years, that's for certain. Whether that has happened equally at the same pace in private practices or in the general dental practices, I'm not quite sure. I didn't work in the last five years as a full-time dentist but I do part-time sessions, but on the whole it has geared up." (Male dentist, community setting, qualified between 10-20 years, Mixed ethnicity, England)

"Obviously in the last few years it has been brought to our attention, we do get more input from GDC or from CQC certainly, they've played a very big part in the last few years of making people aware of how practices should be operating and what dentists should and should not be doing and what's acceptable and what isn't." (Female dental hygienist, dental practice, qualified more than 20 years, White British, England)

A small number of respondents mentioned that they feel that the **registration of DCPs** has already or will make a difference in terms of DCPs feeling more confident to raise concerns and recognising that it is part of their professional duty to do so.

"I think the registration of dental nurses has made a sea change in their responsibilities, it's really put them as part of the dental team such that they feel empowered in the sense that they know what they should be doing and if they're not doing it they'll say 'why aren't you letting me sterilise this instrument?' or something. They'll challenge dentists because they feel now that they're very much more responsible, as they are of course." (Male dentist, dental practice, qualified more than 20 years, White British, England)

"Things have now changed with regulations, whereas 15 years ago anybody could be a nurse, you didn't have to have qualifications, you didn't have to be on the GDC register. I think you just got young girls who just went in, it was a job and it was completely different....So I think standards are higher and I think people are probably more aware of standards now." (Female dental nurse, dental practice, qualified between 5-10 years, White British, England)

Others, however, point to a more **general societal change** where patients and professionals alike are more likely to 'point the finger' because of an increasing tendency towards a blame culture:

"A rampant blame culture which seems to be fanned by the media. All professionals like teachers, policemen, doctors and dentists say they cannot do their job without looking over their shoulders. The problem is clueless politicians and bureaucrats who make policy without any knowledge whatsoever we need wet finger professionals to do that." (Male dentist, dental practice, qualified between 5-10 years, BME, England)

"The issue is much higher on the radar and has created an environment of fear." (Male dentist, hospital setting, qualified less than 2 years, White British, England)

"As for raising concerns, I think we are all aware now of the media, and social media. Nowhere to hide come to mind. We live in a different era. We all have a duty of care." (Female dental nurse, hospital setting, qualified between 5-10 years, White British, England)

There is also a sense that efforts to drive raising concerns up the agenda within **professional training** are having an impact, resulting in newly qualified and younger dental professionals being far more aware of their duty than has previously been the case:

"The younger generation are far more aware of raising concerns. I have been qualified for 35 years…. My juniors are happy to question anything and are aware of the duty to report concerns." (Female dentist, hospital setting, qualified more than 20 years, White British, England)

"Teaching at universities nowadays has changed a lot from 'hands on' to ethics and raising concerns and literally having to know the GDC booklets inside out to pass finals and also get a job." (Female dentist, dental practice, qualified less than 2 years, BME, England)

3.2 Understanding of what constitutes a concern

Some respondents are very clear and confident about what constitutes a concern and what does not, immediately mentioning issues of patient safety or practices

that put a patient or a colleague at risk. Many also differentiate between concerns and complaints and are aware of their own duty to raise concerns.

A minority of these respondents went as far as saying that they would welcome colleagues raising concerns about them, as they see it as an essential part of the process:

> *"I think if a process can be improved then, as much as I would like someone to report, not necessarily report but to raise a concern if they find my work or an aspect of my working not sufficiently safe or appropriate for a patient, I think it's a self-regulation process in a way." (Male dentist, dental practice, qualified less than 2 years, White British, Wales)*

Several respondents working in hospital and community settings differentiated between concerns relating to an individual's competence, behaviours or health and institutional concerns (for example, issues relating to instances of 'cutting corners' because of targets on the number of minutes per appointment or the number of staff on duty).

> *"I guess raising concerns, a complaint often in my view would come from a patient's perspective, whereas raising a concern normally comes from either, for example, a student or another member of the dental team. I think also raising a concern can be more on an institutional level, not just about an individual. In the instance here, it's never happened but I guess if I felt that staffing levels were critically low, meaning that the environment wasn't good in clinic, there was too many people being looked after by one person that could also be thought of as a concern." (Female dentist, hospital setting, qualified between 10-20 years, White British, England)*

Some respondents, who were initially confident in their own understanding of what constitutes a concern, revealed during subsequent discussion that they are not entirely clear on the matter or they have some misapprehensions.

Some respondents assume that raising a concern includes only those concerns which are raised directly with the GDC. Prior to being selected for interview, all respondents were asked to complete a screening survey and, as part of this, indicate if they had ever raised a concern. A significant minority indicated in the survey that they had never raised a concern, only for it to become apparent during the interview that they had actually raised a concern at their workplace and had mis-categorised themselves.

When asked to differentiate between a complaint and a concern, a good proportion of respondents describe a concern as a less serious issue and a complaint as a more serious issue or as an issue that has been formally reported

or escalated. Others used the terms 'concern' and 'complaint' interchangeably throughout their interview.

"I suppose a complaint is a higher level, in my view. A concern is something that could be discussed with the person concerned and the reconciliation could be mutually agreed by discussion. A complaint I regard as the next level up, in other words a complaint is a formal concern." (Male dentist, dental practice, qualified between more than 20 years, White British, England)

"Well, a concern is something that I'm not overly happy about. A complaint is something that if I felt very strongly or I wanted to raise it higher. A concern, I would just have a quiet word with somebody, for a complaint I would escalate it." (Female dental nurse, hospital setting, qualified between 5-10 years, White British, England)

"Yes, what I think is a concern is, if somebody's informally telling you something, if they are worried about something or like, for me, when I was worried about how things were going. A complaint is a more formal thing and it would be stated that I want to make a complaint. I'd listen to a concern, obviously, but with a complaint it's a bit more formalised, is that correct?" (Female dental hygienist, dental practice, qualified more than 20 years, White British, England)

The majority of respondents did not spontaneously mention the term 'whistle-blowing' when describing raising concerns. Those that did tend to mention it in relation to the presence of a 'whistle-blowing policy' or personal reputational issues arising from being labelled as a 'whistle-blower'. Some of these comments suggest that dental professionals see whistleblowing as related to, but distinct from raising concerns per se:

"It's [raising concerns] a bit like whistleblowing, isn't it? People are scared about whistleblowing because they're named and they're going to be treated badly for being the whistle-blower." (Female dental nurse, community setting, qualified between 5-10 years, White British, England)

"No, but whistleblowing is different, isn't it? Whistle-blowing is taking it to the next level where you pass the complaint on up, you don't necessarily deal with it within the practice." (Male dentist, dental practice, qualified more than 20 years, White British, England)

3.3 Identification of concerns

In terms of the process used to identify whether something is a concern that should be raised or not, a number of respondents mentioned a **'friends or family' test**. They think about whether they would be comfortable if their

relative was the patient and, if they would not be happy, then they would raise a concern.

> *"I think probably I would look at it as if that was my mum or my grandma in that chair, would I be happy with the treatment that was being carried out? It is difficult and I imagine everyone has their off days, but there's a difference between actually doing something that would harm or put a patient or another member of staff at risk." (Female dental nurse, dental practice, qualified between 5-10 years, White British, England)*

Some, however, talk about using their intuition to identify issues i.e. if something doesn't 'feel right'.

> *"Something that isn't quite right, that it's nagging away at me, that I feel is going to affect a patient. Yes, that leaves a funny taste in my mouth." (Female dentist, community setting, qualified more than 20 years, Black African, England)*

3.3.1 Perceived 'black and white' issues

The factors that gave rise to the clearest (black and white) determination of whether or not a concern should be raised or not included:

- Where the behaviour is repeated and/or not corrected following an initial mistake.
- Where a fellow professional has health or dependency issues (although it was noted that these situations can be extremely sensitive and challenging to deal with).
- Where the concern relates to or arises from poor care or treatment being given to children or vulnerable adults (with safeguarding issues often top of mind).

3.3.2 Perceived 'grey' areas

It is widely acknowledged that there are grey areas and that it can sometimes be very difficult to judge whether something constitutes a concern. This is **particularly notable in dental practice settings** where dentists are felt to have more autonomy in terms of how they practise. Hospitals are felt to have more standardised processes and procedures and it is, therefore, perceived to be easier to identify when things are being done incorrectly or in a way that is not up to required standards.

> *"I think certainly if you're not a consultant you always have somebody that you can bring a clinical issue to, to make sure that what you're doing is most appropriate. And also our patients, remember, don't pay here and that brings with it a slightly different thing as well in that we're not cost driven. …Whereas I think in practice that's much more open to interpretation and an individual about what they think is clinically right for a patient. We work*

much more within a set of parameters than someone would in practice." (Female dentist, hospital setting, qualified between 10-20 years, White British, England)

"The culture here is much more regimented because it's an NHS strictly governed system. We've got a lot of rules and regulations here to fulfil and we have got to fulfil them and it's a good thing. But in practice we did get away with a lot of other stuff, you're your own boss there." (Male dentist, community setting, qualified more than 20 years, White British, England)

"Yes, I could see that happening in many a practice because you could give 100 dentists the same set of teeth and you'll get 100 different treatment plans. So it could be they don't feel the implant is the correct thing but that doesn't necessarily mean it's wrong." (Male dentist, other, qualified 10- 20 years, White British, Northern Ireland)

Respondents also stated that they find it difficult to judge whether to raise a concern if they **did not directly witness** the behaviour or performance in question.

"Because most dentists work in a single surgery, you may have an inkling of what goes on, so if a patient comes in as an emergency you might see somebody else's patients, but how do you know what's just a one off? Unless you're seeing a lot of their patients, you don't know really." (Dentist, hospital setting, qualified more than 10 years, White British, England)

Some specific issues are raised in terms of identifying concerns related to **registrants who qualified outside of the UK**, both in terms of these registrants being less sure of the usual practices in the UK and UK-qualified registrants being unsure about the appropriateness of practices of foreign colleagues (and sometimes not wishing to raise issues that relate to cultural differences).

"So it's very hard to say exactly what is right and what is wrong regarding a lot of situations because we wouldn't do that in our country but it seems to be generally accepted in here." (Male dentist, dental practice, qualified between 2-5 years, White Other, England)

"She's…Portuguese and I think some of the translation is getting misunderstood. The words she uses tend to put fear into people instead of making them feel at ease and that bothers me, I don't like that but it's a cultural thing and it's a tricky one to do something about that." (Female dental hygienist, dental practice, qualified more than 20 years, White British, England)

"I think where there's a problem of cultural differences with non-UK trained dentists, that's a separate issue, cultural and language differences, that's a separate issue and that's quite hard to comment on really" (Male dentist, dental practice, qualified more than 20 years, White British, England)

Section Summary: Understanding and Awareness

Most respondents are aware of the existence of the GDC's new standards. However, awareness of the detailed content of the standards, including the duty to raise concerns, appears more variable.

Respondents appear to be more aware of the duty to raise concerns if:

- They are working in a role which involves responsibility for training.
- They are working in hospital or community settings, where it is apparent that there has been a recent focus on safeguarding training.
- They are recently qualified.
- They tend to take a proactive interest in their own development and ensure that they keep up-to-date with issues.

Those who had been qualified for some time referenced knowing that they should raise concerns because it is 'common sense', rather than through a conscious or precise knowledge of The GDC's standards.

Some respondents feel that raising concerns is now higher on the agenda than was the case a few years ago.

Some respondents are very clear and confident about what constitutes a concern, immediately mentioning issues of patient safety or practices that put a patient or a colleague at risk. Many also differentiate between concerns and complaints and are aware of their own duty to raise concerns.

- Other respondents, who were initially confident in their own understanding, revealed during subsequent discussion that they are not entirely clear on the matter or they have some misapprehensions.

In terms of the process used to identify whether something is a concern that should be raised or not, a number of respondents mentioned a 'friends or family' test. They think about whether they would be comfortable if their relative was the patient and, if they would not be happy, then they would raise a concern

The factors that gave rise to the clearest (black and white) determination of whether or not a concern should be raised or not included:

- Where the behaviour is repeated and/or not corrected after a mistake.
- Where a fellow professional has health or dependency issues.
- Where the concern relates to or arises from poor care or treatment being given to children or vulnerable adults.

It is widely acknowledged that there are grey areas and that it can be very difficult to judge whether something constitutes a concern. This is particularly notable in dental practice settings where dentists are felt to have more autonomy in terms of how they practise.

4. Barriers to Raising Concerns at a Workplace

Respondents were asked directly about the key barriers that inhibit the raising of concerns within a workplace. These issues were also extensively explored indirectly through discussion of hypothetical scenarios.

4.1 Broad cultural or systemic barriers

There is some reference to the fact that there is **no culture of raising concerns** generally within our society or in the dental profession and still stigma attached to such actions. One respondent referred to it as being seen as 'letting the side down.'

> *"I still don't think that there's a whistle blowing culture within Northern Ireland...I'm speaking generally here because we've some issues with whistleblowing in the hospitals. I still think they talk very nicely but the 'no blame culture' does not really exist. We have legislation that protects whistle blowers that people are not really aware of, that employers are aware of that as much as they should be. So I don't think that 'no blame culture' exists and if somebody did whistleblow within a practice would they be protected afterwards? I'm not sure." (Male dentist, other setting, qualified 20 years or more, White British, Northern Ireland)*

Other dentists and DCPs point to **systemic or wider issues** that require attention, which, they believe, if tackled would mean that there would be fewer concerns to raise. Their focus on these wider issues is, in and of itself, a barrier to raising concerns. They perceive that problems are caused by the NHS England Dental Contract and the Units of Dental Activity (UDA) system (which is discussed further in Section 4.2.4) and that, whilst this system exists, it is seen as pointless raising concerns because these issues need to be tackled at a higher, more strategic level.

> *"And it wasn't that bad when I qualified but Health Service dentistry has never been well funded so people have made a good income from it, an acceptable income from it, by doing it quickly and in large quantities. That doesn't make them very inclined to do things as well as they can." (Male dentist, dental practice, qualified more than 20 years, White British, England)*

One respondent mentioned that the **lack of a systematic revalidation system** within dentistry creates a situation where poor practice can occur and where some professionals would not recognise practices that might be of concern.

> *"The big issue in dentistry as opposed to medicine is there is no revalidation as such. So you could end up on your own in a practice, after graduating, for the next 30 years and you don't really know other dentists or what is*

acceptable or what is not acceptable." (Male dentist, dental practice, qualified less than 2 years, White British, Wales)

Some point to the fact that issues that should be raised as concerns are not always recognised as such, because **poor practice can become normalised** within a working environment. This finding matches previous studies[6] which have found that incremental deviations from normal procedures can gradually become accepted.

"I went into the profession at 17 and that's all you're ever taught or all you're ever told in that environment. That's just what you do. You don't challenge it, you don't do anything about it. And probably if you or I went into a restaurant tonight and we were told this is what has to happen, if that hasn't been touched we bring it back and we put it back out, we would maybe think 'that's not right' but after two or three days you would just think that's what happens in here." (Female dental nurse, hospital setting, qualified between 2-5 years, White British, Scotland)

"Dental nurses are a fine example of this, they may have worked with somebody for 10 years and seen a certain procedure done in only one way, or patients handled in a certain way, and then suddenly somebody does it a different way and they're questioning either what the person's doing now is wrong or what was done before is wrong." (Male dental hygienist, dental practice, qualified more than 20 years, White British, Scotland)

4.2 Workplace barriers

Many barriers related to the workplace, with individuals indicating that they have or would act differently, in terms of raising concerns, in different settings or where the culture and professional relationships are different.

4.2.1 Workplace culture and relationships

Workplace culture is hugely important. Respondents working in workplaces with very hierarchical structures and with a lack of open and transparent processes indicated that they would be less likely to raise concerns than those working within flatter management structures which emphasise a learning culture and the importance of working in a team. The existence of a workplace policy and process for raising concerns is far less important than the culture.

"If the dentist does everything and stays remote from his staff, the staff will not feel that they can approach him. If they are involved in the day to day running of the practice, they have regular practice meetings, they do all the

[6] This finding is highlighted in the Professional Standards Authority's review of academic research in this field "Candour, disclosure and openness - Learning from academic research to support advice to the Secretary of State." October 2013

things they're supposed to. I can't say this for definite and there's no research to back this up, but it's just a feeling that if that culture is there, it is easier for them to raise concerns.." (Male dentist, other setting, qualified 20 years or more, White British, Northern Ireland)

Several respondents (including both dentists and dental care professionals) mentioned that they feel that the typical personality traits of dentists are not always conducive to creating workplace cultures which engender the required openness and transparency.

"There is the autonomy but I think greater than the autonomy is the arrogance, 'this is my business, I'll do what I want', or even 'this is my patient, I'll do what I want." (Female dental nurse, hospital setting, qualified between 2-5 years, White British, Scotland)

"I think all dentists are Type A personalities and we're not good at admitting that we can't do things, we're not good at relinquishing control..... Yes, I don't think you can talk about a culture, no blame, I don't think you could look at raising concerns in isolation. I think it has to be part of a whole practice ethos, if they don't change the entire practice ethos they're not going to change the way they raise a concern." (Male dentist, other setting, qualified 20 years or more, White British, Northern Ireland)

The nature of the relationship between dentists and other professionals in dental practices being very **hierarchical** meant that some respondents feel there are specific and significant barriers to DCPs raising concerns about dentists. These arise from the deferential nature of the relationship (as well as the perceived arrogance of dentists noted above.)

"He's a hygienist so in general they've not got quite the same influence as one of the other dentists so, if he kicks up a fuss about it, he could potentially be moved on basically to a different practice and they would just replace him." (Male dentist, dental practice, qualified less than 2 years, White British, Scotland)

"We're all dental care professionals and we have to be registered to practise and I think that needs to be more embedded into dental care professionals, and to dentists as well. There is a culture that a dental nurse is just a dental nurse and the amount of times I hear that, 'I'm just a dental nurse'." (Female dental nurse, training and education role, qualified between 5-10 years, White British, England)

"So I raised that concern and this same dental adviser did speak to him but he denied it all. I'd put it in writing but he denied it all and nothing ever was resolved. If a dental nurse complains about a dentist and the dentist said it's

not true then the dental adviser believes the dentist." (Female dental nurse, community setting, qualified between 5-10 years, White British, England)

4.2.2 Types of contract

Locums, those who are **self-employed, agency workers or part-time** staff and those working in out of hours settings (outside of their main workplace) can face particular challenges in terms of raising concerns. This is because such staff do not feel as much a part of a team and therefore have less vested interest in making sure things are done correctly (i.e. less connection or attachment).

"I think because I'm part-time as well I don't get to hear about all the day to day stuff. I do often feel a little bit left out, especially when things I should be told about happen" (Female dental hygienist, dental practice, qualified more than 20 years, White British, England)

"I think the issue for her was this is weekend work and this could cause me trouble in my Monday to Friday job, in my week day service. So I think that was the issue for her, and she was just really really apprehensive about doing it." (Female dental nurse, hospital setting, qualified between 2-5 years, White British, Scotland)

Conversely, two respondents (one agency worker and one who was self-employed) felt that it was in fact easier for them to raise concerns as they weren't directly employed by the practice.

"It's like you're complaining to your employer and then you think you may be at risk of losing your job by saying 'hey look, I don't think you're sterilising things right' or doing things right. I think that's a lot harder, it's easier, as I say, when I was doing the agency work because you're that one step removed, your job's not on the line." (Female dental nurse, dental practice, qualified between 5-10 years, White British, England)

"Normally as a hygienist you're probably self-employed as well so you've probably got a bit more leg to stand on if you wanted to complain about someone. I think I'd feel a bit safer in my complaint, whereas working alongside the partner who you wanted to complain about I would feel really nervous." (Female dental nurse, other setting, qualified more than 10 years, White British, England)

4.2.3 Types of setting

Some respondents suggest that concerns are far more likely to be raised in community and hospital settings, as opposed to **dental practices.** In these settings the deferential and hierarchical culture and relationships, which create significant barriers in many dental practices, are said to be less pervasive.

"I've been to various meetings and so on with people from the other NHS Trusts in London, the Special Care Dental Trusts, and all of them the nurses would aggressively report the dentist. It is not a problem in the NHS Trusts at all…..nurses wouldn't have any qualms at all about raising issues about dentists." (Male dentist, community setting, qualified more than 20 years, White British, England)

"In a hospital setting, nurses would have no hesitations to make formal complaints against clinicians because they would have a very different pathway and the clinician would have very little choice in who they work with and who they don't work with. However, in a practice setting, particularly in a rural Welsh area, if you are let go by a practice, which often are undergoing financial pressures so there'd always be a justified reason to let someone go…" (Male dentist, dental practice, qualified less than 2 years, White British, Wales)

The **size of the clinic or practice** is important, with those working in smaller or fairly isolated settings identifying more (as well as different) barriers to raising concerns. In particular, with regard to small practices the following barriers are cited:

- There is less scope for the informant to remain anonymous.
- There are fewer peers with whom to discuss issues.
- There is less likely to be a management structure providing an internal route for raising concerns.

"We have a problem in terms of there are certain clinics where you are on your own as a single surgery practice in a remote location. I say remote because it's quite far from all the hubs…, so working you sometimes feel, especially the less experienced ones, you need to be in the field to be quite confident. I think if you're on your own there's no one you can immediately go to and discuss or ask for a second opinion. So I think those clinics, dentists do feel a bit unsupported in the immediate context." (Male dentist, community setting, qualified between 10-20 years, Mixed ethnicity, England)

"There must be loads of dental nurses like me who are literally in a very small practice with just one other person, they haven't got a colleague to go turn to. Like if I was in a big practice I might think 'he's done something a bit dodgy today, I'll go and talk to the other nurse and see what she thinks'. You've got somebody else to back up, if you're on your own I think it's very difficult." (Female dental nurse, dental practice, qualified between 5-10 years, White British, England)

"If you're a dental nurse and you're working in a practice and see something that's not right, then it quite difficult to blow the whistle because you work there and they are very very small businesses. So it's one thing for somebody

in a Trust for someone to whistleblow, in a very large organisation, it's another thing for somebody when their living depends on it." (Male dentist, other, qualified 10- 20 years, White British, Northern Ireland)

Conversely however, some respondents also raised specific difficulties in raising concerns within **larger companies.** With regard to large, multiple practice corporates, the following specific barriers were described:

- Senior managers in these companies may be less approachable. Such managers may be based in a different office and very remote from those wishing to raise a concern.
- Organisations are so large that a single voice may not be heard.
- Managers are often not dental practitioners and do not have clinical expertise.
- The organisation is too big and powerful to challenge.

"If a nurse maybe raises a concern about a dentist [in a small practice] then it's going to be pretty obvious which nurse raised that concern, but then you also do have the problem with the large corporate companies that it's almost that your complaint could get lost… they often are just a practice full of associates with a manager so sometimes you can feel that you're not being listened to. I've had friends that work at corporate dental practices and have never actually met the directors or the clinical leads in the practice." (Female dental nurse, dental practice, qualified between 5-10 years, White British, England)

"One of the biggest problems now that the biggest corporates in this country for dental practices insist that …. their managers have no dental experience, they all have to come from business management, and this is a huge problem." (Female dental hygienist, dental practice, qualified more than 20 years, White British, England)

"Because [it] has immense power with 400 practices, you just think twice before you start messing around with those things." (Male dentist, dental practice, qualified between 2-5 years, White Other, England)

4.2.4 Competing workplace priorities

The **commercial nature** of non-NHS practices is also felt to be a barrier to raising concerns. Respondents point to instances where the drivers of the organisation are commercial so they are less focussed on and, concerned about, standards of clinical care per se and more focussed on organisational performance and generating revenue. However, there is also the converse view that being profit-led makes tackling concerns more likely (in private practice) because they would not want to lose patients or their good reputation. Some of those working in private practice also feel that they have more time to devote to staff training and CPD than NHS practices.

"I think in general practice, especially in places where there's quite a high competition between clinics, the dentists are quite stressed and they don't have the time to discuss any concerns. They generally go by the flow of things and they don't want to disrupt things, in many ways I think they believe that, if they disrupt it, it affects everything else and the management will come down hard on them, that sort of attitude. So I did find in two corporate clinics that's the general attitude, they're like let's brush it under the carpet, or get along with it, or find another way to sort it. (Male dentist, community setting, qualified between 10-20 years, Mixed ethnicity, England)

In a similar vein, some feel that the **pressures on NHS practices** in terms of meeting targets set within the NHS contract mean that issues that should be raised as concerns are simply ignored.

"When I worked for the NHS actually the stress was unbelievable. The balance between being ethical and achieving the number of UDAs[7] which your principal would want you to achieve, I found that really hard." (Female dentist, dental practice, qualified between 5-10 years, White Other, England)

"So any problems we raised were avoided because obviously addressing them would maybe affect the UDAs, so we were actually told 'not to worry about it at the moment because we're so far behind on UDA targets'." (Female dental nurse, dental practice, qualified between 5-10 years, White British, England)

[7] Since 1st April 2006 NHS dentists in England and Wales have been paid according to how many Units of Dental Activity (UDAs) they do in a year. A contract is drawn up between a dentist and the local commissioning body, which requires the dentist to deliver a certain number of UDAs in a 12-month period for an agreed sum of money. Each dental procedure carried out on the NHS has been classified into a band which determines what patients pay and the amount of UDAs a dentist gets. Depending on complexity of the treatment, a dentist, or dental practice is awarded one, three, or 12 UDAs for each course of treatment. Should a patient need multiple treatments in one go, this would all be carried out under one UDA band meaning that dentists are paid the same for a single filling as they would be for carrying out multiple fillings. Under the contract, the dentist or dental practice must deliver the number of UDAs specified in the contract over the 12-month period. If the dentist/practice fails to hit the UDA target for the year, the commissioning body will take back the money for the UDAs that have not been delivered. Dentists in Scotland and Northern Ireland still get paid on a "fee per item" basis.

4.3 Personal/individual barriers

Whilst many barriers to raising concerns related to the workplace, a great many other barriers were more personal or individual. It is interesting to note that this research found no evidence of 'the bystander effect',[8] even when respondents were probed about this as a possible factor. This may be because, in reality, there tend to be relatively few situations in dentistry where there are several witnesses to an issue of concern.

4.3.1 Age, experience and confidence

A **lack of experience and a consequent lack of confidence** and self-belief is identified as a significant barrier to raising concerns. Many respondents indicate that they would or had raised concerns later in their career, but that they would not have done so in the same situation when they were younger and less established. Respondents making this point were mostly female.

"My confidence is quite high in my ability to do the job. I know, because I've done it a long time, what's right and wrong. Say if there'd been a newly qualified nurse or someone that had come from practice to work in our department, they probably may not have felt as sure or as confident to do what I did." (Female dental nurse, hospital setting, qualified between 5-10 years, White British, England)

"Being older and wise I would do it now, but I think when you're younger you're intimidated by these people, we shouldn't be, but we are. So would I have been able to do it a few years ago with just working in a dental practice? No, I don't think I would have done." (Female dental nurse, hospital setting, qualified between 5-10 years, White British, England)

"I think especially for a younger dentist to raise concerns,….because generally your colleagues are older than you are, even I've found that my nurses are older than I am so there is that sort of difficulty… maybe like an authority thing." (Female dentist, dental practice, qualified less than 2 years, Asian, England)

"It is interesting because if I come across dental nurses who are about my age, in their 30s, 40s or whatever, they're much more robust individuals, they've lived life. Age is a significant factor, I genuinely believe that, I would imagine if there was some kind of audit carried out of some kind that have managed to raise concerns, I'd put money on it the vast majority are older."

[8] The bystander effect, or bystander apathy, is a social psychological phenomenon that refers to cases in which individuals do not offer any means of help to a victim when other people are present. In this context, we refer to it as the propensity to leave the reporting of concerns to others if there are a number of witnesses.

(Male dental hygienist, dental practice, qualified more than 20 years, White British, Scotland)

4.3.2 Doubts over validity

Linked to the fact that there are some 'grey areas' for respondents in terms of whether issues should be raised as a concern or not (see 3.4.2), a barrier exists for some individuals in terms of difficulty judging whether a concern is valid. There is a feeling that they must be confident, beyond all doubt. For these respondents there is a tendency to hesitate, since the consequences for the professional they might be considering raising a concern about are potentially so serious, they dare not risk raising an issue they are not absolutely certain about.

"Well, it may be a false accusation. That's the thing; if it's a false accusation of, let's say sexual misconduct with patients, or something then that's really something that you wouldn't really want to do if you could avoid it." (Male dentist, community setting, qualified more than 20 years, White British, England)

"I think everything's not always black and white, you're supposed to do things this way and that way but you can't always do things exactly the right way. Patients are not robots and you can't just put in exactly the right thing and it's going to be right for everybody, there has to be a bit of shade in there." (Female dentist, dental practice, qualified between 10-20 years, White British, Scotland)

4.3.3 Fears about the personal impact of raising a concern

Many of the personal or individual barriers to raising a concern are fears about the impact on the person raising the concern themselves. A general fear was expressed in terms of having to deal with the **unpleasantness of the response** from the individual about whom the concern is being raised. This arose, in some cases, because of an awareness of how this same individual has reacted to previous patient complaints or concerns.

"Yes, if I'm an Associate or an Assistant or a junior person in a practice owned by some bloke who is ripping off the NHS, I might keep quiet about that because I'm scared. There's some tough guys in dentistry." (Male dentist, community setting, qualified more than 20 years, White British, England)

"I've seen dentists having complaints from patients and I know how they react, so you don't want that to be ten times worse if it was to be the nurse or the hygienist or someone in your own team complaining about you." (Female dental nurse, recently left practice, qualified less than 2 years, White British, England)

Another frequently cited fear is a fear of reprisals within the workplace and an adverse **impact on reputation and future career.** This has been found to be a key barrier in many previous studies. The Professional Standards Authority's (PSA) review of academic research[9] cites *"preoccupations about loss of reputation, position, and advancement as impediments to disclosure."* Amongst the registrants in this research the concern was frequently about being labelled, for the long-term, as a trouble-maker.

> *"If you become the one who gets bullied at work, or you don't get your hours, or whatever reason....You don't want to be the one who's standing there saying, in front of everyone else, and everyone else knows what you've done and no one's going to want to work with you because they think 'if she reports me'." (Female dental nurse, recently left practice, qualified less than 2 years, White British, England)*

> *"Because you don't want to be getting a bad reputation. If you flag somebody up, say it was a different practice, one of the other practices in the town, they might see it as you're trying to damage their patients, steal their patients, and they might start kicking up or even making up stories about your own practice then all of a sudden it becomes a bitter war." (Male dentist, dental practice, qualified less than 2 years, White British, Scotland)*

This fear was exacerbated because of a perceived lack of any protection for those who do raise concerns:

> *"Because even if you say that you're not allowed to fire someone or whatever, there's so many other things that could happen in your workplace with bullying or being frozen out or making sure that no one wants to work with you." (Female dental nurse, recently left practice, qualified less than 2 years, White British, England)*

The fear of reputational and career impact was particularly acute where the person in question was influential, senior or in a position of power and / or well connected:

> *"I was reminded that this man was actually local secretary of the BDA and it wouldn't have been appropriate for me to voice complaints outside the practice." (Female dental hygienist, dental practice, qualified more than 20 years, White British, England)*

This fear about reprisals in the workplace linked closely to a very real fear of a personal **economic impact.** This would occur where raising a concern

[9] "Learning from academic research to support advice to the Secretary of State," October 2013 – Professional Standards Authority.

ultimately leads to being sacked; being made redundant at a later date (both of which were particularly seen as a possible outcomes in dental practices); or not being given a good reference by the employer. There is some concern evident regarding cuts being made in the NHS, the general economic conditions being unfavourable and consequent difficulties there might be in getting an alternative job.

"Unless you've got another job to go to, then you may raise grievances, but I can't see many people in practice raising a grievance against their boss without the consequences of them losing their job. And the dental community's quite small, they're probably not likely to get another one." (Female dental nurse, hospital setting, qualified between 5-10 years, White British, England)

"It's accepted that dental nurses, for example, if you've got concerns about your boss, well, if you raise a concern about your boss and he's your employer then that's your job probably gone down the pan." (Male dental hygienist, dental practice, qualified more than 20 years, White British, Scotland)

"They [the GDC] got back to me after a while, writing me a letter, and they wanted my consent to start proceedings against him. But I needed, to be honest with you, a reference from him to find another job so it put me in a very very awkward position. So I couldn't and I was candid with them, I said 'listen, this will put me in a very awkward situation and I wouldn't be able to find another job', she said 'okay, we'll investigate anyway but you won't get any feedback'." (Female dentist, dental practice, qualified between 5-10 years, White Other, England)

One respondent, who used to work for a defence organisation, raised the point that if you raise a concern it could impact on the cost of personal indemnity insurance (although he felt that it should not be a significant barrier to raising a concern. However, this point was not mentioned by other respondents.

"If you're raising a concern about somebody else, it can impact on your own indemnity insurance. I used to work for the defence organisation, I used to work for dental protection for a number of years as a local adviser." (Male dentist, other setting, qualified more than 20 years, White British, Northern Ireland)

4.3.4 Fears about the process of raising a concern

Related to these fears about the personal impact of raising a concern were fears about the process that would ensue once a concern had been formally raised. A **lack of time/too busy** was mentioned by few respondents, in passing, as a barrier – the perception being that there would be a protracted process taking up

a lot of time although this was rarely cited as a significant factor. More significant for some was **the likely stress,** hassle and upset of raising a concern:

"It's been interesting for me to see how terribly terribly, terribly upset they've [dental nurses] been, and one of them described it as being witness to a crime, which I thought was quite an interesting turn of phrase, she wasn't able to sleep for weeks, she was off work, she was really distressed. Not because of what she's seen but because she's raised this thing, that she's got to that point where she had to say something." (Female dentist, community setting, qualified more than 20 years, Black/African/Caribbean/Black British, England)

"I think it would drag me into a long drawn out process, that I neither would have the time or patience to be involved in. I also feel that I could bring my values and standards into question and create an added stress that I do not need." (Male dentist, dental practice, qualified between 5-10 years, White British, Northern Ireland)

4.3.5 Relationships and loyalties

The PSA's review of academic literature in this field[10] found that collegiality and loyalty to workplace are regularly cited as barriers, it points out that *"professionals may choose not to report their colleagues' mistakes both because they would feel they were betraying them, and because there is a hope that if roles were reversed their colleagues would do the same for them."* This kind of effect was also cited by respondents in this research. **Loyalty to peers** and especially to close working colleagues was a key barrier. Often the individual in question may be a friend as well as a colleague, making the idea of raising a concern about their practice even more unpalatable.

"I was put in a very difficult position because I really liked the practice, I liked the guy but I started to realise he's not really that nice because what he was doing to patients was not that great, he's lied about stuff." (Female dentist, dental practice, qualified between 10-20 years, White British, Scotland)

"I think it's a lot easier to raise a concern with somebody that you don't directly work with, so another dentist in the same town, if you were seeing a lot of their patients you could raise a concern a lot easier that way. If it was somebody inside your own practice, I'd be more inclined to try and speak to them first of all and try and sort it out before going to the GDC about it." (Male dentist, dental practice, qualified less than 2 years, White British, Scotland)

[10] "Candour, disclosure and openness -Learning from academic research to support advice to the Secretary of State", October 2013

Even where such personal loyalties do not exist, dental professionals describe having a propensity to give colleagues the **benefit of the doubt**, recognising that people do make mistakes.

> *"I kind of wanted to give the dentist the benefit of doubt, I just thought maybe because she's new, she's not worked in the private sector before, she was NHS at her last practice, perhaps that transition is going to take her a little while to settle into." (Female dental hygienist, dental practice, qualified more than 20 years, White British, England)*

The dental professional's feelings of connection or attachment to their workplace are also important – workplace loyalty (as opposed to personal loyalties.) This factor can work in different ways – an emotional commitment to a team or workplace can (as previous studies have found) bring in loyalty factors that make raising concerns difficult. On the other hand a lack of engagement and commitment to the workplace can, conversely, lead to an apathetic approach to raising issues, a kind of 'why bother?' effect, as described by one respondent:

> *"I think it has a little bit to do with passion for the things, if you're interested in things, if you care what you're doing. I think there's a lot of people, they know that they're doing wrong but actually don't care, and be encouraged to care about your job and being encouraged to maybe get paid more so you feel like it's actually nice to go to work...if everything is crap anyway so why would I care? Why would I risk everything for saying something?" (Female dental nurse, recently left a practice, qualified less than 2 years, White British, England)*

4.4 Process barriers

Few cited inadequate policies or procedures or a lack of knowledge of how to raise a concern as a barrier. This replicates the data from the Annual Registrant Survey 2013[11] which indicates that 88% of registrants would know who to go to, to raise a concern.

However, some uncertainty exists about the nature and structure of local resolution mechanisms with some confusion about the correct route for raising concerns locally, outside of the immediate workplace. There is also some suggestion that dental professionals are not sure what to do next if, and when, they report a concern and nothing seems to happen. Nevertheless, where respondents indicated that they had not known how to raise a concern they simply spoke with colleagues or looked it up and this, therefore, was not perceived as a significant barrier.

[11] Annual Registrant Survey 2013 conducted on behalf of the GDC by Enventure.

Some respondents made the point that even if the workplace has a policy on raising concerns it does do not mean professionals are any more likely to raise concerns.

> *"There are pathways to be followed but I would often have the impression that these are very much put in place in order to appease the CQC and various bodies." (Male dentist, dental practice, qualified less than 2 years, White British, Wales)*

> *"I suppose you could have a policy in place for that, but it still wouldn't make it easier to raise a concern if the concern was about something that's going to affect your job. You may still not be able to raise a concern." (Male dentist, other, qualified 10- 20 years, White British, Northern Ireland)*

In terms of process, however, a key barrier is lack of access to impartial and confidential advice at the very early stages of thinking about whether to raise a concern or not.

A key barrier related to the process of raising concerns is that there was perceived to be no possibility of remaining anonymous. If anonymity could be provided this would make a significant difference to the likelihood that concerns would get raised. This point was raised both with regard to local resolution but also very frequently with regard to raising concerns with the regulator and so this is also covered at Section 6.1.

How workplaces have been seen to deal with previous concerns is also an important influencer as to whether concerns are raised or not.

4.5 Avoidance and escape

It is apparent that there is a process of weighing up whether to raise a concern or not where the benefits of raising a concern are weighed against the risks/disadvantages of doing so. Some respondents indicated that they did this and then decided to try to avoid the situation rather than raise a concern. For example, dental nurses asking to be put on a rota with a different dentist to avoid the one about whom they have concerns; or the registrant leaves their job rather than raising a concern. One dental nurse indicated to an agency that she did not want to be sent back to a particular practice. Several respondents had previously decided to leave a workplace rather than tackle the issue.

> *"My first practice there was two owners, if I have a problem with one of them, how do I bring up with the second one when the two are best friends. This is the thing, there are a lot of things that make any type of raising concern, making complaint that makes it so complicated because it's not an easy thing, who do you bring it up with and, if you don't know things and know the procedure, it's easier to just leave it, be unhappy or leave and hopefully find*

another job because you don't know what to do." (Female dental nurse, recently left practice, qualified less than 2 years, White British, England)

"What I had done to manage it, which I know wasn't the right thing in a way, was I just stopped sending patients to him so I then I didn't have to feel bad about the patients coming back with the wrong thing being done and it being done badly." (Female dentist, working in a hospital, qualified more than 20 years, White British, England)

"{In response to a scenario.} She may well leave rather than face the situation of raising concerns. This is a very stressful situation for her and she may take the easier option of walking away or worse just turning a blind eye." (Female dentist, community setting, qualified more than 20 years, BME, England)

One respondent mentioned that her defence organisation had encouraged her to leave her job, rather than take the concern further:

"I went back to my Defence Society, told them what had happened and they said just leave the practice. I said 'should I not be taking it further?' because I thought you're supposed to take this further and they said 'no, you don't need the hassle'. So I'm thinking right, totally conflicting advice to what you get from all your lectures, the courses you go on. Obviously you take the advice from your Defence Society because they're looking after you, I suppose." (Female dentist, dental practice, qualified between 10-20 years, White British, Scotland)

Section Summary: Barriers to Raising Concerns at a Workplace

The key barriers that inhibit the raising of concerns within a workplace are:

- Broad cultural or systemic issues, including:
  - No general culture of raising concerns and a stigma attached to doing so.
  - Focus on wider systemic issues that make raising a concern seem pointless.
  - The lack of a systematic revalidation system.
  - The fact that poor practice can become normalised and therefore is not raised.
- Workplace barriers, including:
  - Workplace cultures which are hierarchical and not open or transparent.
  - Types of contract which mean the worker has less vested interest and connection with the workplace and patients.
  - Barriers that arise in particular settings – there were seen to be fewer barriers in hospital or community workplaces than is the case in dental practices.
  - Larger and smaller workplaces have distinct barriers. In smaller workplaces the following barriers are cited:
    - There is less scope for the informant to remain anonymous.
    - There are fewer peers with whom to discuss issues.
    - There is less likely to be an internal route for raising concerns.
  - In large, multiple practice corporates, the following specific barriers were described:
    - Senior managers may be less approachable.
    - Such managers may be very remote from those wishing to raise a concern.
    - Organisations are so large that a single voice may not be heard.
    - Managers are often not dental practitioners and do not have clinical expertise.
    - The organisation is too big and powerful to challenge.
  - Competing workplace priorities which create barriers to raising concerns.
- Personal and individual barriers, including:
  - Younger, less experienced and less confident professionals finding it much harder to raise concerns.
  - Doubts or hesitation over the validity of concerns.
  - Fears about the personal impact of raising a concern, including fears of being labelled a trouble-maker and of losing employment, with the consequent economic and long term career implications.
  - Fears about the process – with perceptions of it being stressful and time-consuming.
  - Loyalty and emotional connection to peers and colleagues.
- Process barriers, including:
  - Some uncertainty about local resolution routes
  - Lack of access to impartial advice prior to raising a concern.
  - Lack of anonymity.

In a relatively high number of cases, respondents indicated that they had adopted avoidance strategies, in order to escape the need to make this decision instead of tackling the issue directly.

5. Views and Issues Surrounding Local Resolution

5.1 Understanding of local resolution

For most respondents the term 'local resolution', in the context of raising concerns encompasses both the resolution of concerns **within the workplace** and the escalation of such concerns to **a local intermediary**. However, a minority of respondents appear to be conscious of only two levels – local resolution in their own workplace; and the GDC:

> *"I think local resolution should be understood in two steps: first within the practice or the senior clinician in a group of practices, and if that doesn't take anywhere then a second step - the local health board or PCT." (Male dentist, dental practice, qualified between 2-5 years, White Other, England)*

> *"I see the local resolution is within your work team and would only involve GDC when the issue can't be solved within the workplace, or if it is a very serious case." (Female Dental Nurse, Dental Lab, qualified less than 2 years, White British, England)*

Most respondents intuitively feel that concerns should be resolved within the workplace, with the individual in question if possible, or (if not) within the management structure, prior to any escalation to an external organisation. This also came out qualitative research as part of the Annual Registrant Survey 2013[12].

> *"I would never escalate anything unless it was dangerous or serious, that couldn't be dealt with first with the individual. I know how complaints can be made and false accusations and, until I was sure I'd exhausted all the avenues and the person wasn't going to modify his behaviour, then I would have no choice but to do it." (Female dental nurse, hospital setting, qualified between 5-10 years, White British, England)*

There is some confusion about the existence of a local intermediary with whom concerns could be raised prior to contacting a national organisation, with some English respondents mentioning local 'Health Boards' as a possible route or referring to PCTs which no longer exist. **Confusion** was apparent amongst some dental professionals regarding the identity of the appropriate intermediary, with some saying that the appropriate routes to local resolution (over and above their own workplace) are unclear:

> *"How do you get in touch with the local PCT? It doesn't seem very easy." (Dental hygienist, dental practice, qualified between 11-20 years, White British, England)*

[12] Annual Registrant Survey 2013 conducted on behalf of the GDC by Enventure.

"In the NHS it used to be possible to get in touch with the RDO (Regional Dental Officer) but in the new system the whistle-blower seems to have to contact the commissioners who are hidden away somewhere in NHS England." (Male dentist, community setting, qualified more than 20 years, White British, England)

Respondents also point out that the process and appropriate routes for local resolution are clearer for dental professionals in some settings, than is the case for others. For example, the situation is clearer for those working within the NHS than is the case for those in private dentistry:

"But the local Health Board in my area, like to emphasise the point to me, that if the problem is private dentistry, they will do nothing about it...they are not interested.....They will only deal with it if it is affecting NHS patients....despite the particular dentist doing both NHS and private work. So they choose to ignore some of it, what then?" (Female dentist, dental practice, qualified 11-20 years, White British, Scotland)

During discussions within the Bulletin Board, where dental professionals from the different home nations and regions were able to discuss and share their perceptions of local resolution, the view was expressed that routes for local resolution seem to be less clear in England than is the case in the devolved nations.

Respondents were asked to outline their understanding of what kinds of concerns should be dealt with and resolved locally and which should be escalated to the GDC. Some respondents were of the opinion that attempts at local resolution should always be pursued in the first instance and that the GDC should only be involved in cases where this process fails:

"If the registrant works for a salaried service then it is obvious to me that the concern/complaint should be thoroughly investigated at that level and then depending on the nature of the complaint a decision will be made whether to contact the GDC. If a resolution cannot be reached locally, then the GDC need to be involved." (Female dental nurse, community setting, qualified between 5-10 years, White British, England)

Whether or not an issue should be raised with the GDC was also felt to be influenced by the severity and complexity of the concern. In general it was agreed that the GDC should be the last resort in resolving a concern:

"It would be sensible to 'save' the severe and complex cases that have not been resolved locally to the GDC." (Female dentist, community setting, qualified more than 20 years, BME, England)

However, some respondents expressed discomfort at this idea as they have a lack of trust in the local resolution process:

"I don't completely agree that the GDC should be left until last resort, as some issues which should be reported, might then be 'swept under the rug' by managers and staff but definitely should have been raised with GDC." (Female dental nurse, currently studying, qualified 2 - 5 years, White British, England)

For some, the decision about what should be resolved locally and what should be raised with the GDC comes down to the difference between the risk of harm to patients and actual harm having occurred.

"If there has been a risk to patient safety then the GDC must be informed. However if there is a risk to patient safety …that has not taken place yet, then local resolution would be my first choice. An example where local resolution may apply could be - if there has been a sudden increase in patient minor complaints due to a dentist's attitude towards patients." (Male dentist, dental practice, qualified between 5-10 years, White British, Northern Ireland)

There was some sense that too many cases are being escalated, too easily, to the GDC. Some respondents perceive that the GDC encourages this and does not, conversely, seek to encourage local resolution. Some respondents are firmly of the opinion that the GDC is just not interested in local resolution but actively wants things to be escalated.

"They [local Health Board] do not want to investigate complaints, they have the manpower, they don't want to spend the money or time investigating complaints. So, therefore, they have basically said to everybody 'if you've got a problem, phone the GDC'....and the GDC have gone 'yippee, we'll investigate everything', where they are acting against their own guidelines, there's no evidence of local resolution." (Male dentist, dental practice, qualified more than 20 years, White British, England)

"Nice to hear the discussion going towards local resolution to solve problems but I don't think that's what the GDC will want - control by external organisations (CQC/GDC/NICE/etc.) is the new religion I'm afraid." (Male dentist, community setting, qualified more than 20 years, White British, England)

"The GDC should generally be a last resort but if the patient reports to dentist to the GDC then I get the impression they don't delegate it back locally first, they just launched a full-scale investigation." (Female dentist, dental practice, qualified between 11-20 years, White British, Scotland)

Whilst others agreed that too many concerns are being raised with the regulator rather than going through the local resolution process, they do not necessarily see this as being something that the GDC is encouraging or desires:

"Although this structure {local resolution} is in place in Scotland, we do not see enough of the low-level cases being addressed using this structure/approach; instead it is addressed via the GDC fitness to practice." (Female dental nurse, hospital setting, qualified between 2-5 years, White British, England)

5.2 Local resolution in practice

A number of respondents mentioned that they had raised concerns with their workplace or other intermediary organisations (for example, a Health Board) and that the information was not wanted and/or not acted upon. As a result, the concern was not taken any further and was not escalated to the regulator.

This inaction or rejection of concerns at a level below the regulator creates a situation where the person attempting to raise a concern either:

- Feels they have done their duty by initially raising the concern and feels it is no longer their responsibility to act further.
- Feels frustrated by the situation but unsure what they could or should do next to take the issue to the next level, since they do not have the support of their first port of call to take it forward.

"She didn't seem interested so I said 'in fact, I think I might just speak to the GDC' and she literally backed out the room and started reversing up the corridor as fast as she could, she didn't want to know." (*Female dentist, dental practice, qualified between 10-20 years, White British, Scotland)*

"So I waited and nothing happened so I reported it again because I said 'I'm not happy about that, somebody should deal with it' and forwarded it again and my manager, again, acted and passed onto him that we'd not heard and we never ever heard from them. So, basically it fell into a big black hole and nothing was ever done about it." (Female dental nurse, community setting, qualified between 5-10 years, White British, England)

"Because I've had occasions where I did fall out with the manager, I said I wasn't really happy about the treatment that was going on and I didn't feel comfortable with and the manager was 'what do you expect me to do?...It's up to you, do you want to make a complaint?' and in the end it was how could I raise a complaint because it will come down to me." (Female dental nurse, recently left practice, qualified less than 2 years, White British, England)

"They said that they had had a chat with her and that they were going to come and review it in a month. Well, a month has passed and they haven't so you kind of think gosh, this is not going to be resolved. So I don't quite know where we go from here." (Female dental hygienist, dental practice, qualified more than 20 years, White British, England)

This issue was further explained by respondents who gave their perceptions of why employers and other intermediaries reject and ignore concerns. They cited a number of perceived reasons for inaction including:

- A wish not to disrupt day to day operations.
- Concerns about the impact on waiting lists or financial targets.
- A fear of tackling difficult individuals.
- Concern about reputational damage.
- Hoping that the situation will be resolved naturally by the individual about whom the concern is being raised leaving.

"Waiting list, waiting list, because he [the individual about whom the concern was raised] is getting through the waiting list of orthodontist patients. Because for many, many years there was a huge waiting list for orthodontist treatment." (Female dentist, dental practice, qualified between 10-20 years, White British, Scotland)

"Even though it's NHS, as in hospitals, every person that goes through that door has got a price on their head, they sit down that's £150, they have a tooth removed under local anaesthetic that's £175. So everything generating is money, cancel a whole clinic because we've had to suspend that person, you're losing thousands of pounds a day." (Female dental nurse, hospital setting, qualified between 5-10 years, White British, England)

"But the line manager has one to ones and appraisals with this person and this person is tricky to handle, so I think there's already been experience of very difficult situations, this person doesn't listen to anyone." (Female dentist, community setting, qualified more than 20 years, Black/African/ Caribbean/Black British, England)

"So from a selfish point of view, it's harder and harder for us to get rid of this person because that kind of information travels, but the problem is still here we are, this person's still seeing patients and doing God knows what." (Female dentist, community setting, qualified more than 20 years, Black/African/Caribbean/Black British, England)

One respondent described a situation where the only way to get the concern taken forward was to go to their Dental Defence organisation and get their point of view about the risks of letting the person continue their work. This was the only way that her employer could be persuaded to take the concern seriously.

"They [the hospital] were saying 'maybe your good surgeon is really good and this guy is just average' and we were saying 'no, no, we've done the audit and he is way outside the norm of any surgeon'. And it wasn't until we contacted the Dental Defence Union and said 'so your company are insuring the hospital basically, if we gave you this audit what would you say?' and they said 'he shouldn't be doing this operation', we then took that to the hospital management and at that point they stopped the guy doing the operations..... The trouble is, if you try and do it on a level that I do which is complain to the PCT, which as far as I knew was the next level up to complain to and they just say 'go away'." (Dentist, hospital setting, qualified more than 10 years, White British, England)

Section Summary: Views and Issues Surrounding Local Resolution

For most respondents the term 'local resolution', in the context of raising concerns encompasses both the resolution of concerns within the workplace and the escalation of such concerns to a local intermediary.

A degree of confusion was apparent amongst some dental professionals regarding the appropriate intermediary, with some saying that the appropriate routes to local resolution (over and above their own workplace) are unclear.

Appropriate routes for local resolution are clearer for dental professionals in some settings, than is the case for others.

Some respondents were of the opinion that attempts at local resolution should always be pursued in the first instance and that the GDC should only be involved in cases where this process fails.

Whether or not an issue should be raised with the GDC was also felt to be influenced by the severity and complexity of the concern.

There was some sense that too many cases are being escalated, too easily, to the GDC.

Local resolution in practice:

A number of respondents mentioned that they had raised concerns with their workplace or other intermediary organisations (for example, a Health Board) and that the information was not wanted and/or not acted upon.

This inaction or rejection of concerns at a level below the regulator creates a situation where the person attempting to raise a concern either:

- Feels they have done their duty by initially raising the concern and feels it is no longer their responsibility to act further.
- Feels frustrated by the situation but unsure what they could or should do next to take the issue to the next level, since they do not have the support of their first port of call to take it forward.

This significant barrier to concerns being raised with the regulator was further explained by respondents who were keen to give their perceptions of why employers and other intermediaries reject and ignore concerns. They cited a number of reasons they perceived to be the reasons for inaction including:

- A wish not to disrupt day to day operations.
- Concerns about the impact on waiting lists or financial targets.
- A fear of tackling difficult individuals.
- Concern about reputational damage.
- Hoping that the situation will be resolved naturally by the individual about whom the concern is being raised leaving.

6. Raising Concerns with a Regulator

Many of the barriers to raising concerns in the workplace are also relevant when it comes to potentially raising a concern with a regulator. This section of the report focusses on the differing barriers that arise for dental professionals in raising concerns at this higher level.

6.1 Specific barriers

The research has also highlighted a number of barriers that relate specifically to registrants raising concerns with the GDC (or another relevant regulator) directly.

Doubts over validity present a barrier to raising concerns at a local level. These doubts are even stronger when it comes to raising issues with the regulator. There is a perception that the informant has to be absolutely certain about a concern before acting. There is simply a **higher threshold for reporting concerns** to the regulator and a sense that the informant must have clear and complete evidence before doing so.

> *"I think the thing you've got to think about is what your threshold is for raising concerns and sometimes, for example in the instance I'm talking about, I suspected a member of staff was taking drugs based on lots of short term sickness, being late all the time and a few other soft indicators but nothing that I could tangibly say I could report to the GDC, for example. I didn't have any evidence of patient harm or anything else so it came to another route where the pharmacist reported it because they were worried about the prescriptions being issued, so they had evidence of something they were concerned about...Because it seems like quite a big measure, reporting something to the GDC, unless you've got either a bit more tangible evidence of it, at what point do you raise that to the regulator, I don't know." (Female dentist, hospital setting, qualified between 10-20 years, White British, England)*

The **regulator is seen negatively and is mistrusted** by many registrants. To some extent this reflects a wider disillusionment with the establishment; a sense that those we are supposed to trust or used to trust can no longer be relied upon as honest brokers.

> *"Looking back at the headlines over the last few years in the media, it has been a succession of scandals…it has created an atmosphere of disillusionment in the establishments we were meant to trust. The media and phone hacking, the MPs and their expenses, the Police and their cover-ups, NHS (Stafford), the Banks (PPI, LIBOR and counting), the BBC. Before they became headlines, they were all "concerns to be raised"..... Will it not make people question the validity of a system?" (Male dentist, community setting, qualified 11-20 years, mixed ethnicity, England)*

In the case of the GDC, this negativity has been exacerbated by the recent fees increase and advertising campaign (which is perceived as encouraging patients to make complaints). The general mistrust of the regulator means that many of the respondents indicate that they would be extremely reluctant to raise concerns with them.

This general mistrust can be further explored and broken down into specific barriers:

- A widely held perception exists that the **Fitness to Practise (FtP) process will be stressful** and long-winded and that whistleblowers are offered little support during the process. This was particularly off-putting if a registrant is acting alone and without the support of colleagues or the backing of local managers.

  "I'm not saying it's right or it's wrong but the nature of the hearings and what actually happens within them, I just don't know that you would ever want to put yourself into that environment....Raising it with the regulator, I think I would be looking at the support of my internal structure to do that with me, I don't know that I'd want to do it on my own." (Female dental nurse, hospital setting, qualified between 2-5 years, White British, Scotland)

  "There were two dental nurses who raised concerns, it went all the way to the GDC in the end but it was delayed and quite a protracted thing. I think at the end of the whole process they were quite stressed and they were quite poorly...A lot of people around the colleagues at that time often wondered whether it's worth going through all that stress?" (Male dentist, community setting, qualified between 10-20 years, Mixed ethnicity, England)

  "I think people don't want to raise concerns themselves. It's perhaps due to fear of being ripped to shreds by barristers in a court room situation. Stress. Not wanting to have to go to meetings with colleagues that they have raised concerns about..."awkward!" Having to take time off work to be involved in case meetings. Travelling hundreds of miles to GDC headquarters given the cost and time implications." (Female dentist, dental practice, qualified 11-20 years, White British, Scotland)

- There is concern that the **GDC will be punitive or unfair** (leading to an unwillingness to put a fellow professional in the situation of being judged by the regulator.) The GDC is seen by some dental professionals as not understanding clinical practice, and / or as being too much 'on the side' of the patient or complainant within the FtP process. Specific mention is also made of a discomfort that the GDC will widen the investigation beyond the specific concern being raised.

"Getting jumped on or them investigating it to an extent and looking at areas which you weren't maybe complaining about in the first place and finding fault in other bits and pieces which you maybe didn't think were much of a concern or hadn't noticed at all." (Male dentist, dental practice, qualified less than 2 years, White British, Scotland)

"Things are handled in a very heavy handed sort of a way, perhaps it's not always fairly judged, for example, and it just takes a very long time to come to a resolution. If you raise a concern it can take months to a year to sort something out. So I just think people think 'is that really the right way?' or 'how big does the issue need to be for me to want to do that if that's what's going to happen?'." (Female dentist, hospital setting, qualified between 10-20 years, White British, England)

"When you look at why people are being erased now, they're just minor little silly things that only require a telling off really. It's just draconian, why is this happening? It's crazy. I think it's completely wrong." (Male dentist, dental practice, qualified more than 20 years, White British, England)

"He would be up in front of fitness to practise hearing, they would sort of blame him for everything, there would be a massive hearing, there would be no understanding of what actually happens in a surgery and it would be Kafkaesque because that is, in my opinion and in a lot of older dentists' opinion, that is what is happening now." (Male dentist, dental practice, qualified more than 20 years, White British, England)

One respondent also has a strong negative impression of the punitive nature of the GDC from the website.

"Well it's [the website] certainly coming across as punitive … the General Medical Council, for example, doesn't disclose anywhere nearly as much in terms of details of the cases, they often will make recommendations to improve a process and the number of cases that are held by the GMC, even though there's many more registrants, would indicate to me that too many cases end up in front of a GDC fitness to practise panel, which I know the GDC is addressing but it's something I would find a concern." (Male dentist, dental practice, qualified less than 2 years, White British, Wales)

- A **lack of anonymity** for the informant was a key barrier to contacting the regulator over a concern. In terms of raising concerns to the GDC, there is some uncertainty over whether it can be done anonymously. Furthermore, some were concerned that they would immediately be revealed by the GDC, with no control over their identity being exposed.

"I don't know if it can be anonymous because I can remember thinking, as well, 'I wonder if I can pretend to be a patient and complain'.....If you can do it without them knowing but, yes, it's exactly that, worried about them finding out that you'd done it. Would they then get a phone call like: 'a nurse from your practice has complained about your cross infection'? That would be the worry." (Female Dental Nurse, Currently re-training, qualified between 2-5 years, White British, England)

- A perception also exists, amongst some registrants that the GDC will only take action regarding a concern if a patient has also complained.

""If I go to the GDC and say 'I have concerns' about a practitioner, they'll say 'yes, but nobody's ever complained about it'." (Female Dentist, hospital setting, qualified more than 20 years, White British, England)

6.2 Feedback from those who have raised a concern with the GDC

Those who had direct experience of raising a concern with the GDC made up only a small sub-sample within this research (and therefore their feedback cannot confidently be interpreted as being representative of the general experience.) Nevertheless, those with this experience had much to say about it. A brief outline of their views is provided in part to provide context but also to show that the negative perceptions about what may happen if a registrant blows the whistle to the regulator, may well be being disseminated by those with direct experience of the process.

Feedback from those who have been informants in FtP cases is largely negative, with particular criticism about lack of communication, lack of support and the length of the process. Some respondents were extremely angry about their experiences and the negative repercussions that raising a concern had had for them. Much dissatisfaction stems from the perception that the GDC did not act on the information provided, meaning that they suffered the consequences of raising the issue for no result.

"I just felt failed by them really, absolutely ultimately failed. It's a waste of time really, being a registered technician, there's no point in it whatsoever. Unless they can be bothered to police their situation and look after dental technicians." (Female dental technician, recently left job, qualified more than 20 years, White British, Female)

"I do think just keep us more informed really. We just felt like we were having to find out what was going on. Like I say, we bought the local paper to find out the outcome of the Court hearing. We got a call from them and also there was lots of press there so they might have some interest and I felt they maybe could have helped us and guided us with that a little bit more."

(Female dental nurse, dental practice, qualified between 5-10 years, White British, England)

The following points regarding the process were raised specifically:

- The lack of appropriate, tailored forms for registrants raising a concern and the provision of standard rather than tailored responses from the GDC.
- Being asked for evidence or more recent evidence (and having the case closed as a result of lack of evidence) when the guidance says no evidence is required to raise a concern.

"Then they got all uppity with me because I started saying 'actually I shouldn't have to provide evidence because I'm raising a concern, your booklet says that, and I have already provided evidence, which I didn't need to provide, in the form of x-rays' blah blah blah and they were like 'you're being evasive'. They were horrible." (Female dentist, dental practice, qualified between 10-20 years, White British, Scotland)

- Concern that the case workers are not experts in dentistry and don't understand the issues.
- A lack of protection from the negative repercussions of raising a concern (for example, a respondent not being able to get another job in the sector and one respondent being taken to court for leaving a job without serving his notice when his employer refused to take his concerns seriously).

Section Summary: Barriers to Raising Concerns with the Regulator

The research has highlighted a number of barriers that relate specifically to registrants raising concerns with the GDC (or another relevant regulator) directly, these include:

There is a perception that the informant has to be absolutely certain about a concern before acting. There is simply a higher threshold for reporting concerns to the regulator and a sense that the informant must have clear and complete evidence before doing so

- The regulator being seen negatively and mistrusted by many registrants.
- A widely held perception exists that the Fitness to Practise process will be stressful and long-winded and that those raising concerns are offered little support during the process.
- There is concern that the GDC will be punitive or unfair (leading to an unwillingness to put a fellow professional in the situation of being judged by the regulator.)

A lack of anonymity for the informant was a key barrier to contacting the regulator over a concern. In terms of raising concerns to the GDC, there is some uncertainty over whether it can be done anonymously. Furthermore, some were concerned that they would immediately be revealed by the GDC, with no control over their identity being exposed.

7. Triggers or Enablers of Raising Concerns

Many of the triggers and enablers that might encourage registrants to raise a concern about a fellow professional represent the removal of, or are directly opposite to, the barriers outlined in Section 4.

7.1 Policies, procedures and regulation

Dental care professionals clearly feel that the likelihood of them raising concerns has increased significantly since the introduction of registration:

> *"Registration of DCP's has brought with it accountability and I think this has raised our expectations of fellow professionals. Individuals are more concerned than ever on protecting themselves so are more willing to raise a concern if a colleague is not performing as they think they should and quite rightly so!" (Female dental hygienist, dental practice, qualified between 11-20 years, White British, England)*

> *"I feel that it is now part of our duty as a DCP to raise issues and concerns. As you said we are now legally accountable for the care our patients receive too." (Female dental nurse, hospital setting, qualified between 5-10 years, White British, England)*

Some respondents who work in hospital or community settings indicated that they feel that there is a robust system that encourages the raising of concerns. The systems in place mean that issues have to be dealt with internally wherever an incident report form is completed. The existence of this clear protocol was an enabler, although it was mentioned by relatively few respondents.

> *"We've quite a good regimented structure which actually I think it works quite well. If there's something serious happening then it gets taken to high level management within the Trust." (Male dentist, community setting, qualified more than 20 years, White British, England)*

> *"We would be encouraged to do an incident report form to highlight it because as soon as that incident report form goes in, that then generates something that's got to be done, so the clinical director's got to action or react on it." (Female dental nurse, hospital setting, qualified between 2-5 years, White British, Scotland)*

7.2 Workplace triggers and enablers

Workplace culture

Workplace culture is clearly important with hierarchical and closed workplace cultures create barriers. Conversely **open, sharing and supportive team-based cultures** create workplaces that enable and facilitate the raising of concerns.

"It's just having that culture where people are encouraged to talk about something that happened, without necessarily fear of recrimination or whatever in there. So say you have your practice meeting, your team meeting, you talk about things that went wrong and without it being a feeling that you're going to get told off, punished whatever. It's kind of learning through mistakes." (Female dentist, hospital setting, qualified between 10-20 years, White British, England)

"Freedom from fear, sympathetic management who's got their finger on the pulse of what's going on and managers who are on tap rather than on top." (Male dentist, community setting, qualified more than 20 years, White British, England)

Being valued by an employer or by management within a workplace means that individuals are more likely to care about their job and therefore to raise concerns. Whether the workplace is open to learning from mistakes, and is thus somewhere that encourages concerns to be aired, is partially judged on how well previous concerns have been dealt with. Where concerns have been taken seriously and properly dealt with this gives **confidence in the senior management** and or the process that they will deal with other concerns effectively.

"Because his behaviour was so evident, I did keep a little book of the patients names where I knew he had carried out what I thought was poor dental treatment so I could refer back to them if I needed to but I think with that case it was so evident that he was working inappropriately that I was quite confident that the right thing would be done" (Female dental nurse, dental practice, qualified between 5-10 years, White British, England)

"It is always down to leadership; whether it is innovation in the management, empowerment of staff, enabling critical appraisal, or even the use of appropriate technology, it is down to a "person, or people" who inspire or lead the way in a place of work. As members commented above, whether you call it a "relaxed workplace" or a "happy" work place, it will be down to a culture of values and principles of an inspired leadership, that will develop such places." (Male dentist, community setting, qualified 11-20 years, mixed ethnicity, England)

Workplace culture is clearly influenced by leadership and management, but the ability to turn to and gain support from like-minded colleagues is also an important enabler for raising concerns. Gaining **strength in numbers** by raising concerns jointly with other professionals was cited as a key potential enabler. The ability to do this is clearly enhanced where team working and sharing is encouraged within the culture.

7.3 Personal / individual triggers or enablers

An individual sense of **ethical and or professional duty** is important and mentioned by many respondents as being the major, often the most significant, prompt for raising concerns. A number of registrants explicitly stated that the GDC's standards per se, are far less relevant than this simple ethical and moral imperative to act. This comes from within, from the individual professional's conscience.

> *"If I had to maybe talk myself into whistleblowing then the way I would do that is to remind myself that I have an ethical duty as a qualified dental nurse to do that, because once it becomes part of your job then it maybe takes a bit of responsibility off that individual." (Female dental nurse, dental practice, qualified between 5-10 years, White British, England)*

> *"I always think in my mind, one, I'm registered for a reason because it took a long time to qualify and, two, I've got a duty of care and whether I'm a dental nurse or a dental surgeon or whoever, I have a duty of care to that person." (Female dental nurse, hospital setting, qualified between 5-10 years, White British, England)*

> *"I think whilst it is expected of me, I think the standards are a minimum standard…..So not because of the GDC, the GDC is a framework to mandate people to act, but it's professional understanding and acting in the patient's best interests in the absence of the GDC standards." (Male dentist, dental practice, qualified less than 2 years, White British, Wales)*

Clearly, in terms of personal and individual enablers many are **the direct opposite of the individual and personal barriers** outlined in Section 4. For example, those who are very experienced and older and those who have strong feelings of confidence through being well established and respected in their workplace are more likely to raise concerns.

> *"In the NHS practice, I've been there eight and a half years, I feel valued, I feel my opinions and my input to practice is really considered so I would feel somebody would happily listen to me." (Female dental therapist, dental practice, qualified between 10-20 years, White British, Wales)*

Likewise, when the issue is felt to be black and white (it is serious or repeated behaviour or involves vulnerable patients), this removes any doubts over the validity of the concern and this makes it easier to raise.

> *"It's not acceptable and I don't care if they don't like me. Patient care is paramount, cross infection is extremely important and they need not to be lax and just think… because they wouldn't have liked that instrument in their mouth and it's not acceptable under any circumstances and, as soon as I saw*

it happen, I had to address it." (Female dental nurse, hospital setting, qualified between 5-10 years, White British, England)

The **removal of the fears** that act as a barrier can also act as triggers. For example, some registrants reported feeling more able to raise the concern because they had left the situation or practice and, therefore, no longer feared an impact on their own employment position. In the same way, as the fear of a negative impact on one's future career dissipates, this can enable the propensity to raise issues. One respondent indicated that he is much more likely to flag up issues now (later in his career), not because of a lack of confidence earlier in his career, but rather because he is no longer concerned about the possibility of damaging his career.

"I'm 61 and if they want to fire me for saying what I think is wrong then they can do so. If I was younger, I had a career, I might think twice about that, and I presume the same thing goes with flagging things up." (Male dentist, community setting, qualified more than 20 years, White British, England)

One respondent was honest enough to admit that a key trigger for raising her concern with the GDC was that she wanted a degree of revenge on the dentist she had worked for. This respondent had been forced out of the practice because she had raised concerns about hygiene standards.

"This might sound bad……retribution. It might sound really bad but you feel violated when someone tells you to go, dismisses you basically, so you want to act back." (Female dentist, dental practice, qualified between 5-10 years, White Other, England)

7.4 When avoidance fails

As outlined at 4.5, a number of respondents indicated that they had adopted avoidance strategies, in order to escape the need to make the decision about raising a concern. A key trigger appears to occur when the registrant can no longer work around the issue or live with it.

"But when my new colleague arrived and we were going to have to send some patients somewhere, because the other surgeon couldn't just do all the work, then we raised it with the hospital." (Dentist, hospital setting, qualified more than 10 years, White British, England)

Respondents also describe being triggered into raising concerns that they might otherwise have tried to work around, as a situation escalates. This might be, for example, because the person they have a concern about reacts badly or because management inaction forces their hand.

"*But he wasn't a bit concerned about it, that's what made me raise it as well, it wasn't a mistake, it was a deliberate 'oh, that's what I do every time I see somebody'." (Female dental nurse, community setting, qualified between 5-10 years, White British, England)*

"Our concerns were ignored by our manager and her managers. So we actually said to them that we are concerned and if they're not going to take it further then we would ourselves, and at that point the situation did get addressed and it did resolve in the dentist being erased from the register." (Female dental nurse, dental practice, qualified between 5-10 years, White British, England)

Registrants also admitted that they become more likely to raise an issue the more it **impacts on them** and their work very directly and in the short term (for example, they are seeing more patients or patients are leaving the practice).

"It might sort of jeopardise your relationship within the practice but you wouldn't really want to work somewhere where you had all these patients that you had to keep challenging, you've got gum disease and you've got caries and… I probably wouldn't want to work there if I had to do it." (Female dentist, dental practice, qualified less than 2 years, Asian, England)

Section Summary: Triggers or Enablers of Raising Concerns

Many of the triggers and enablers that might encourage registrants to raise a concern about a fellow professional represent the removal of, or are directly opposite to, the barriers identified.

- Dental care professionals clearly feel that the likelihood of them raising concerns has increased significantly since the introduction of registration.
- Workplace culture is clearly important with open, sharing and supportive team-based cultures, creating workplaces that enable and facilitate the raising of concerns.
- Gaining strength in numbers by raising concerns jointly with other professionals was cited as a key potential enabler.
- In terms of personal and individual enablers many are the direct opposite of the individual and personal barriers outlined previously. For example, those who are very experienced and older and those who have strong feelings of confidence are more likely to raise concerns.
- The removal of the fears that act as a barrier can also act as triggers. For example, some registrants reported feeling more able to raise the concern because they had left the situation or practice and therefore no longer feared an impact on their own employment position.
- In addition, an individual sense of ethical and or professional duty is important and mentioned by many respondents as being the major, often the most significant, prompt for raising concerns.

8. Suggested Improvements

Respondents were asked to suggest how the process of raising concerns could be facilitated and how registrants could be further encouraged to raise concerns.

8.1 Introduction of an anonymous helpline

The most common suggestion was the **introduction of an anonymous helpline** which would provide initial guidance on whether the concern should be formally raised or not. Respondents wanted to be able to speak to an expert on a confidential basis prior to raising a concern formally as they feel this would offer a fresh perspective on the issues particularly where they do not have colleagues they can discuss the issues with.

> *"I would like to see an anonymous helpline so that if I had any concerns/ issues I could talk it through with someone first as I work in a small practice with no other colleagues to get advice from it is always good to get someone else opinion. I feel a help line would be good for all DCP's as it always good to get impartial advice may not always be appropriate to talk to colleagues." (Female dental nurse, dental practice, qualified between 5-10 years, White British, England)*

It was pointed out that if such a helpline were introduced, it would need to be widely advertised.

> *"I feel it should be an independent anonymous help line - that is widely advertised so everyone knows it exists. DCPs in small practices frequently don't know who to contact with concerns and don't know their obligations to maintain their registration more education is needed." (Female dental hygienist, dental practice, qualified between 11-20 years, White British, England)*

Some saw a helpline solution as being particularly important for specific audiences, particularly for those working in small dental practices and for dental nurses, some of whom are not members of a defence organisation and may fall under the insurance of a dentist. However, others thought that all DCPs should be encouraged to pay for the services of a defence organisation.

> *"I think one of the issues would be to enable DCPs to access dento-legal advice, which is not well communicated as they are often on the insurance of another dentist. Possibly an anonymous and confidential advice line, paid for by the GDC but not reporting to them?" (Male dentist, hospital setting, qualified less than 2 years, White British, England)*

> *"For dentists - salaried/hospital services should have a whistleblowing system in place so (in theory) you can sideline them as dentists needing a helpline.*

Similarly corporate dentists should have a whistleblowing system in place, but insofar as there may be a commercial reason for covering up deficiencies they will need access to any proposed helpline. High Street dentists (associates and assistants) definitely need a helpline....For DCPs - a dedicated helpline to cover all DCPs may be useful due to their disparate nature and lack of access to Defence organisations." (Male dentist, community setting, qualified more than 20 years, White British, England)

However, whilst many felt there was need for an anonymous helpline, there were a number of challenging issues associated with its provision and operation and some scepticism about its true benefit. There was no consensus in terms of which organisation should provide the helpline. Some placed importance on the helpline being provided by an independent organisation and queried if it really could be anonymous if provided by the GDC. However, they were unsure which other organisation could provide the service given that they may have insufficient dental expertise to be able to offer good advice and/or they may have conflicts of interest. Few wanted the BDA or the defence unions to offer the service.

"Anything that can help gets my vote, my concerns are 1) these people need to be unbiased, unattached, have a good knowledge of dentistry and be able to obtain the full picture 2) advice must be given with the aim of what's not just best for the clients but also for the profession going forward 3) though I am in total agreement with total transparency I think we also need to be able to ensure spite and malice are filtered out." (Male dentist, dental practice, qualified more than 20 years, White British, Wales)

"An independent body sounds good but needs wet fingered dentists who work in the NHS to advise or help. Not some expert who has many degrees but no work experience in the real world." (Male dentist, dental practice, qualified between 5-10 years, Asian/British Asian, England)

"I would like to see an independent anonymous helpline I work in a very small practice with no other colleagues apart from the dentist and would be nice to be able to raise any concerns / complaints I may have to an anonymous body for advice on what do and where to go next. As to who should run the organisation it would be good if the GDC could fund this but then if they did, I can't see it being anonymous and of course it would need to be run by dental professionals." (Female dental nurse, dental practice, qualified between 5-10 years, White British, England)

"I'd favour the GDC as they (should!!) have the expertise in advising on the issues. I've got misgivings about encouraging peripheral organisations such as unions or associations from being included as advisors as they may not properly understand the facts and may have hidden agendas. I'm not sure

about the BDA." (Male dentist, community setting, qualified more than 20 years, White British, England)

Some felt that if the GDC provided such a service, they would err on the side of caution and advise callers to report all concerns so as to 'cover themselves'. This would result in a further exponential rise in the number of concerns and some felt that the GDC would not have sufficient resources to cope.

"I am now torn as to whether it should be the GDC who have an anonymous helpline/ report line, as I am not convinced they would be able to cope with the number of reports which would presumably increase if they can be anonymous. Generally I think it SHOULD be the GDC as it is directly in line with what they 'do' i.e. protect the patient and ensure DCPs and dentists are working to correct standards but I am concerned that they would still not do anything with the complaints." (Female dental nurse, student, qualified between 2-5 years, White British, England)

Some queried the funding of a helpline service and if their fees would have to rise to pay for it. There was also scepticism about whether it will actually work or whether it will just be another layer of bureaucracy which needs to be funded.

"Having a helpline separate to what's currently available for dental professionals i.e. GDC, Defence organisation, BDA would it not be adding another channel of frustration for dental professionals??...unless the organisation was put in position to act, was totally an impartial body and provided appropriate guidance and advice irrespective of the level of concern/complaint. I personally do not think it would be the way forward as I don't believe a helpline would be impartial and it could potentially sit on the fence." (Female dental nurse, community setting, qualified between 5-10 years, White British, England)

"By the time you are at the stage of raising concerns an informal helpline is pointless. What would be much better is specific advice on exactly how to raise concerns so the cases do not get knocked back. I would suggest that in a lot of cases when concerns are raised it is about more than one issue or event, that the person raising the concerns has thought this over for some time and are probably under reporting what has been happening. So a helpline to help us decide if concerns need to be raised is a bit patronising. Whatever form it is, it should be part of the GDC with a degree of autonomy." (Female specialist, community setting, qualified more than 20 years, England)

"However, having thought some more about this...who's going to pay for it? Yes, us again! and why should we when we already pay the GDC and our defence organisations and possibly the BDA?" (Female dentist, dental practice, qualified 11-20 years, White British, Scotland)

Some felt that a helpline service with an emphasis on local resolution would be more beneficial rather setting something up at a national level.

"Good idea but agree that only worthwhile if completely anonymous, and that the operators are adequately trained and knowledgeable of the ins and outs of dentistry. It may be more useful (and a better use of funding) to have a designated individual in each area who could be reached anonymously (via email?) to sort out problems at a local level rather than funding a nationwide phone line." (Male dentist, dental practice, qualified less than 2 years, White British, Scotland)

"Internal resolution is again the best way forward. I also wonder whether having a nominated person on a local health board level with whom you can discuss concerns on an anonymous level would be of use, in particular to smaller practices where anonymous complaints and team meetings may not work quite so well. This person could be somebody known to a larger proportion of the dental community, so could be a long standing dentist in the area, or somebody involved in the dental admin side of the health board." (Male dentist, dental practice, qualified less than 2 years, White British, Scotland)

"Also instead of approaching someone like GDC, it may be less intimidating to approach regional bodies (similar to DRO/Deanery which can be seen as neutral) which may also offer the support and advice to the whistle blower. If they investigate and find a case to answer, then it is appropriate for them to take it on to higher levels with their expertise and resources, than potentially leaving it to the victim to fight a long way alone." (Male dentist, community setting, qualified 11-20 years, mixed ethnicity, England)

8.2 Changing workplace cultures

Some suggested solutions centring on **changing negative workplace cultures**, particularly tackling very hierarchical structures which can inhibit team working, openness and transparency (and, therefore, the raising of concerns). They stress that there is a need for workplaces to ensure that members of staff know that it is safe to air issues. This process will need to encompass a number of elements including:

- Persuading management that it is their role to set the right climate within the workplace.

"In my experience good practice stems down from the principle/owner/manager. If they have good ethics and are good at what they do and have a positive attitude this is reflected amongst all the staff and the working environment." (Male dentist, dental practice, qualified 6-10 years, White British, Northern Ireland)

- Improving the recognition/respect for DCPs so that they feel validated and able to raise concerns.
- Encouraging practices to appoint someone as a HR manager or similar who staff can go to with issues.

  "Policies and procedures for whistleblowing, equality and diversity and raising grievances for example should be in place with processes allowing to be audited if and when necessary. A sort of HR representative should be incorporated into the practices as most of the time the principal/ manager may not be the right person to address the HR issues from staff. I suppose what I am trying to say is a micro model of what larger practices/ NHS Trusts have in place in their organisations e.g. HR issues, clinical supervision is what should be considered." (Female dental nurse, community setting, qualified 6-10 years, White British, England)

- Setting up systems (for example, an anonymous complaints box) where people can raise issues (and ideally suggest solutions).

  "We have an anonymous complaint box and the manager addresses the issues during the practice meeting without mentioning any names. If it is a serious complaint regarding a single person, he usually seeks advice from higher up first and deals with it in complete confidentiality. It has helped - does not necessary address the issues completely and has got its limitations as well." (Female dentist, dental practice, qualified between 5-10 years, White Other, England)

- Setting up a 'buddy system' for new members of staff.

  "One idea which did seem to make a difference was the 'buddy' system for new members of staff. This not only gave support to them, but also someone to turn to if there was a problem. I know this only works if the 'buddy' reacts and is unafraid to do so." (Female dental hygienist, dental practice, qualified between 11-20 years, White British, England)

The PSA's review of literature in this field notes that: *"The absence of a blame culture may not be sufficient…to encourage staff to be open about mistakes. Much of the literature suggests that there are positive steps that need to be taken by employers to encourage effective disclosure."*[13]

[13] "Learning from academic research to support advice to the Secretary of State," October 2013 – Professional Standards Authority.

8.3 More training and guidance

Other solutions focused on **more training or more guidance** in various forms, ensuring that all dentists and DCPs are aware that raising concerns is part of their professional role. Suggestions included:

- Training to enhance leadership/managerial skills.
- Training workshops run by GDC on the issue of raising concerns (to include non-clinical practice managers).
- Use of scenarios (such as those used as stimulus in the telephone interviews) as a training tool.

"If we are to play out scenarios of raising concerns as part of training, regularly in our workplace, it will become a natural part of our workplace culture, and empower all staff members." (Male dentist, community setting, qualified 11-20 years, mixed ethnicity, England)

- The production of a toolkit on raising concerns for use in practices and other settings, including best practice relating to how to feedback on concerns raised.
- A requirement for non-clinical continuous professional development for registrants, which would cover issues like raising concerns. For example, it is suggested that raising concerns is added to the course on Ethnics/Law and that this is made mandatory.

8.4 Peer to peer review mechanisms

A number of respondents suggested that the development of more support networks and **peer to peer review mechanisms**, particularly for smaller practices, would help to support better practice in terms of raising concerns.

"From my experience, professionals will admit mistakes and they will like to rectify the mistakes if there is a setting where they can freely interact, with confidentiality...If there is a space where professionals can interact freely and vent their thoughts without being judged, it may be a liberating experience and even make a leap in their learning process. It needs to be developed by the leadership of a regulatory/training body/deanery…..Clinical governance meetings within teams would help, but more compact groups of few professionals would be more helpful and allow 'qualified whistleblowing'." (Male dentist, community setting, qualified 11-20 years, mixed ethnicity, England)

"Busy people tend to want to turn the other way so helpline or similar will not be used for vulnerable staff that are isolated then a support network can have a role. Locally we used to have a support groups for Dental Therapists and hygienists for audit, Peer Review and professional support. This was very successful on lots of levels so perhaps somehow expanding this so that dental teams in practice also feel part of a bigger dental network. Locally we have

Audit meetings for all salaried staff covering a large area. They are very well attended, cover a lot of issues, informally and we are now extending the opportunity to the DCPs for them to meet collectively on the same days." (Female specialist, community setting, qualified more than 20 years, mixed ethnicity, England)

"To really help all registrant groups regardless of experience would be really good support/mentoring networks within their own professional groups." (Male dental hygienist, community setting, qualified more than 20 years, White British, Scotland)

Others also mention the perceived advantages of **local dental advisors** and Referral Dental Officers (RDOs).

"The RDO was a good service - if the GDC were to spend any money usefully on some good clinicians going into practices and seeing what is done and talking to all members of the team - rather than focusing on getting patients to complain they could use a service like this to ensure we have good standards - helping rather than criticising- suggesting areas for improvement and then going back and reviewing progress (or not)." (Female dentist, hospital setting, qualified more than 20 years, White British, England)

"I think local groups that practices can join which discus peer review and how to run a good practice would be useful to some. The problem may be that the troublesome practices wouldn't join in. I think local dental advisors need to be employed and visit practices regularly and know their patch and staff. This person should be approachable and offer to hear any problems that staff may have. If this person has good people skills and visit regularly they can see whether staff are being empowered and encouraged to speak out in the practice." (Female dental nurse, community setting, qualified between 5-10 years, White British, England)

8.5 Specific actions for the GDC

Some suggested solutions focus on the **GDC's reputation** amongst registrants generally and, particularly, improvements relating to the **FtP process** itself (including better communication with and support for informants).

"Something needs to change…. The profession needs to have confidence in the GDC…. Recent issues with retention fee have not helped. A more streamlined quick and efficient system is needed. With all things like this some people will be caught up in it having not done much and then face months and months of massive stress to them, until it is addressed. Speed and efficiency is needed, also a realistic approach." (Female dentist, community setting, qualified more than 20 years, BME, England)

Some feel that registrants would be more likely to raise concerns if the GDC demonstrated that there was a proportionate approach and that issues would be dealt with sensitively and appropriately.

"I would expect the GDC to act with discretion, be supportive to those involved in raising the concern, understand what it has taken to do this. I would expect the GDC to act efficiently and fairly swiftly for all parties concerned in order that stress is contained." (Female dentist, community setting, qualified more than 20 years, BME, England)

"GDC needs to be efficient and prompt with their responses and in the collection of evidence and data. Judgements should be made by colleagues from the profession as opposed to lay members to ensure they have understanding of the context and setting or it should be properly balanced." (Female dental nurse, hospital setting, qualified between 2-5 years, White British, Scotland)

There were a number of specific practical suggestions for the regulators:

- One respondent who had raised a concern with GDC felt that the current online form is more suitable for the public than for registrants and that there should be a form tailored for registrants.
- The provision of online guidance with a checklist that helps navigation through the process.
- Clarification over whether registrants need to present evidence when raising concerns or not.
- Provision of induction for those trained overseas.
- Ensuring that the presence of policies and processes (and levels of staff awareness) relating to raising concerns are checked at inspections.
- One respondent suggested that the GDC should have some regional presence so that potential informants are not deterred by the time and cost of having to travel to a London-based hearing.

"Maybe they [GDC] could have a couple smaller offices dotted round the country or a mobile case hearing unit?" (Female dentist, dental practice, qualified 11-20 years, White British, Scotland)

Section Summary: Suggested Improvements

Respondents were asked to suggest how the process of raising concerns could be facilitated and how registrants could be further encouraged to raise concerns.

The most common suggestion was the introduction of an anonymous helpline which would provide initial guidance on whether the concern should be formally raised or not

- Some saw a helpline solution as being particularly important for specific audiences, particularly for those working in small dental practices and for DCPs.
- Whilst many felt there was need for an anonymous helpline, there were a number of challenging issues associated with its provision and operation and some scepticism about its true benefit.

Some suggested solutions centring on changing negative workplace cultures, particularly tackling very hierarchical structures which can inhibit team working, openness and transparency (and, therefore, the raising of concerns). These include:

- Persuading management that it is their role to set the right climate within the workplace.
- Improving the recognition/respect for DCPs so that they feel validated and able to raise concerns.
- Encouraging practices to appoint someone as a HR manager or similar who staff can go to with issues.
- Setting up systems (for example, an anonymous complaints box) where people can raise issues (and ideally suggest solutions.)
- Setting up a 'buddy system' for new members of staff.

Other solutions focused on more training or more guidance in various forms, ensuring that all dentists and DCPs are aware that raising concerns is part of their professional role. Suggestions included:

- Training to enhance leadership/managerial skills.
- Training workshops run by GDC on the issue of raising concerns.
- Use of scenarios.
- The production of a toolkit on raising concerns for use in practices and other settings, including best practice relating to how to feedback on concerns raised.
- A requirement for non-clinical continuous professional development for registrants, which would cover issues like raising concerns.

A number of respondents suggested that the development of more support networks and peer to peer review mechanisms, particularly for smaller practices, would help to support better practice in terms of raising concerns.

Some suggested solutions focus on the GDC's reputation amongst registrants generally and, particularly, improvements relating to the FtP process itself (including better communication with and support for informants.)

9. Conclusions and Recommendations

9.1 Conclusions

The overall aim of this project was to build on previous research and gain an in-depth understanding of the circumstances leading registrants to decide to raise a concern. The research has identified many of the same barriers and triggers to raising concerns as have been found in other studies covering a range of health-care and other professions.

Deciding whether or not to raise a concern is a highly complex process which involves many and varied rational and emotional processes. The individual's decision is also clearly affected by the situation they find themselves in – the nature of the concern and the nature of their workplace. Policies, procedures and regulation appear to be much less important than a number of other factors, but they do play their part.

Figure 2 is a modification of the Norm-activation Model (Klöckner & Matthies, 2004) of pro-social behaviour. It presents a suggested model or process whereby pro-social or desirable behaviour is followed or not.

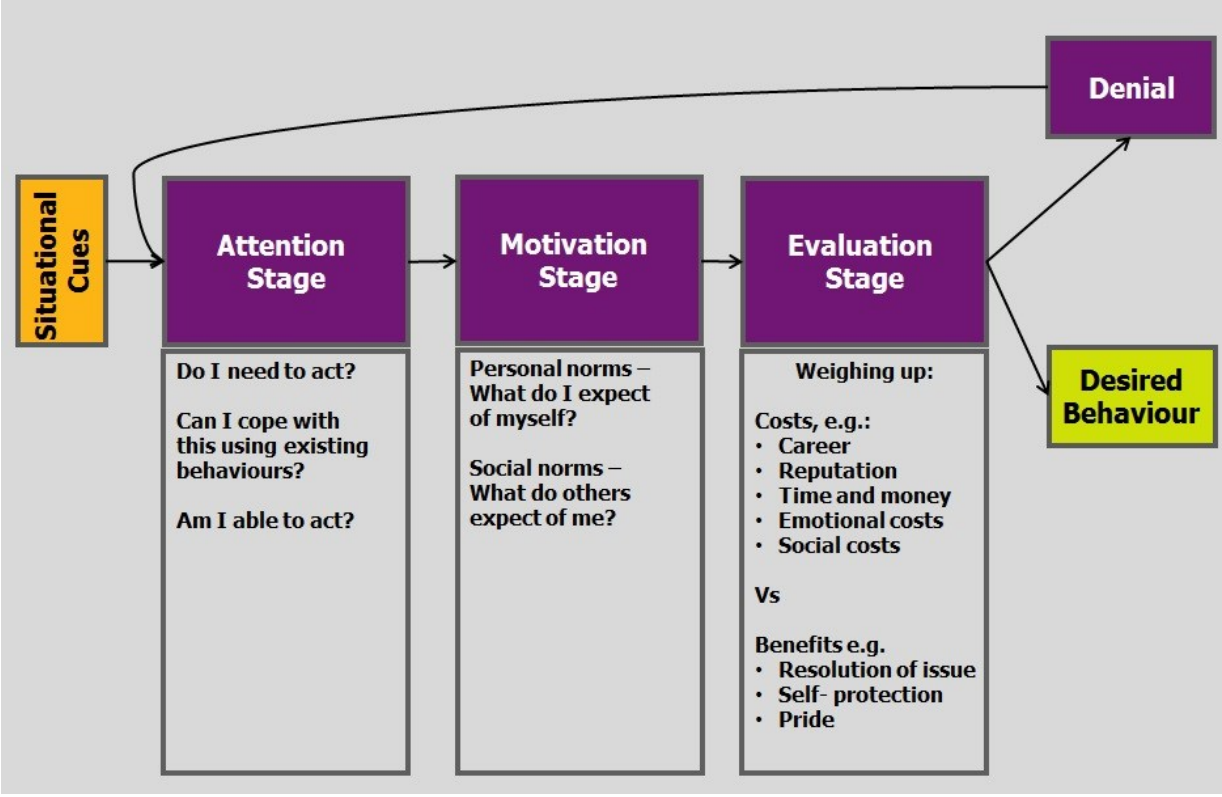

Figure 2 – Modification of the Norm-activation Model (Klöckner & Matthies, 2004)

Whilst registrants do not describe this process per se, the key elements illustrated have certainly been reflected in this research.

Situational cues lead the individual to consider whether there is a need to raise a concern, during the **Attention Stage**. These cues might include the seriousness of the issue itself; the workplace procedures and protocols and the wider regulatory and policy context. The registrant will then consider whether or not they need to and are able to act. There is a good deal of evidence that if a concern can be 'worked around' there is a strong likelihood that this is the choice that will be made.

During the **Motivation Stage**, norms – both personal and social – are important. These dictate what the registrant expects of themselves and what they perceive others will expect of them. Whilst a strong, personal and ethical imperative will act as a trigger to raising a concern; there is evidence that 'giving the benefit of the doubt' and being loyal to fellow professionals is also a strong social norm within the profession which leads many not to act.

The **Evaluation Stage** of the model is possibly the most important and the most complex. It is here that the registrant will weigh up the costs and benefits of raising a concern. A key issue for the GDC to consider is that, for many of the professionals interviewed, the costs of raising a concern are clearer and more top of mind than the perceived benefits. Costs are personal and severe; benefits are more altruistic and less tangible – and many doubt that they exist at all.

The GDC's ability to influence and affect registrants' behaviour with regard to raising concerns, in terms of direct regulatory actions, may be limited. However, there are clearly opportunities for the regulator, along with other key partners, to develop strategies of support, training and culture change in order to lessen and remove some of the barriers identified.

9.2 Recommendations.

The following recommendations are made arising from the research:

1. Awareness of the specific duty to raise concerns, as set out in the new standards, is not universal. Targeted communications raising the profile of this duty amongst registrants should be considered, particularly aimed at: those working in dental practices; those who have been qualified for a long time; and those not involved in training.
2. Registrants are particularly concerned that levels of awareness need to be raised amongst non-clinical practice managers or owners. The GDC should consider how this might be achieved.
3. Given that some barriers to raising concerns are said to arise from systemic issues caused by the NHS England Dental Contract; and that there are some reported instances where respondents raised concerns at a local level with intermediary organisations and that the information was not wanted and/or

not acted upon; the findings of this research should be shared with NHS England and more widely discussed with local NHS organisations and other stakeholders in order to seek shared solutions.

4. Lack of anonymity is a key barrier to contacting the regulator. The GDC should consider whether it is possible to address this and provide anonymous reporting routes.
5. The potential solutions and improvements outlined in detail within Section 8 of this report should be examined, considered and where appropriate discussed with relevant partners and dental care employers with a view to possible implementation. These are:
   a) The introduction of an anonymous helpline which would provide initial guidance on whether the concern should be formally raised or not.
   b) Solutions centring on changing negative workplace cultures, particularly tackling very hierarchical structures which can inhibit team working, openness and transparency.
   c) Training or more guidance in various forms, ensuring that all registrants are aware that raising concerns is part of their professional role.
   d) The development of more support networks and peer to peer review mechanisms, particularly for smaller practices.
   e) Actions to improve the GDC's reputation amongst registrants generally and improvements relating to the FtP process itself.
6. The particular needs of younger and newly registered dentists and DCP's will be worthy of particular consideration in developing any solutions. Whilst those who are newly qualified are more aware of their duty to raise concerns, they appear to be much less likely to have the necessary confidence to do so.

Appendix A: Respondent Profile

Category	Audience	Telephone depths
Experience of 'Concerns'*	Has raised a concern with the GDC	9
	Has raised a concern with employer/place of work	20
	Has had a concern but not raised it with either employer or place of work	2
	Has not had a concern	5
Professional group	Dentist	18
	Dental Care Professionals (including Clinical Dental Technicians; Dental Hygienists; Dental Nurses; Dental Technicians; Dental therapists; and Orthodontic Therapists)	18
Location	England South	11
	East/Midlands	9
	England North	8
	Scotland	4
	Northern Ireland	2
	Wales	4
Setting	Dentist Practice	19
	Hospital	6
	Social Services / Community	7
Experience	Less than 2 years	4
	2-5 years	3
	6-10 years	10
	11-20 years	6
	21 years or more	13
Gender	Male	15
	Female	21
Ethnicity	White	29
	BME	7
Urban/Rural	Urban	29
	Rural, including remote	7
Size of practice	Single handed	5

* Recategorised to reflect actual experience rather than that stated on their response to the original screening survey

Appendix B: Research Instruments

GDC Raising Concerns Discussion (

1 Discussion Guide

GDC Raising Concerns Scenarios F

2 Scenarios