Ipsos MORI

Patient and Public Survey 2013

Research Report Prepared for the General Dental Council

General Dental Council | protecting patients, regulating the dental team

Contents

Executive summary

This report contains the findings of the Annual Patient and Public Survey 2013 carried out by Ipsos MORI for the General Dental Council (GDC). Specifically the study was designed to capture patient and public awareness and perceptions of the GDC and provide insight into key policy areas. The 2013 survey followed previous surveys in 2011 and 2012, using the same methodology – a representative, face-to-face survey with c.1600 people in the UK. The 2013 study also includes qualitative telephone interviews with eleven members of the public and 6 qualitative focus groups with 55 members of the general public. The project also employed a qualitative element to complement the quantitative work as it allows for a more exploratory approach, to provide an in-depth understanding of some of the topics covered and gather further insights into underlying attitudes highlighted by the survey.

The reliability of the survey results depends on the base size for each question (that is, the number of people asked each question). Some questions were asked only to a proportion of the sample. The smaller the base size, the less reliable the result tends to be, as the margin of error increases. A full explanation and description of statistical reliability for each base size in the survey can be found at Appendix A.

Awareness and understanding of dental regulation

Almost nine in ten people believe that dentists are professionally regulated (86%) and this is seen as important; two in three give it the highest importance (66% score it as 10 on a scale of 1 to 10).

Awareness of the GDC remains relatively low amongst the general public. When presented with a list of organisations and asked to select which, if any, are responsible for regulating dentistry (and respondents are allowed to choose as many as they feel apply) around one in four people pick the GDC (25%). The British Dental Association (44%) and the NHS (29%) are selected more frequently. One in five people say they have definitely heard of the GDC before the survey, and this is lower than last year (2013: 15%, 2012: 20%). This year, people are more likely to express slightly more uncertainty (27% say they think they have heard of the GDC). Those people with ethnic minority origins are less likely to say they have heard of the GDC than their white counterparts (9% vs 15% definitely heard of the GDC).

Even after being informed about the GDC's role, understanding and expectations of its role are varied. For example, almost seven in ten people are willing to believe that there is a publicly available register of dental professionals (69%), and lists of specialists (68%) produced by the GDC.

The focus groups show that on finding out what the GDC does, participants feel that its work is very important. Participants suggested that the GDC should provide them with more information about what it does primarily through more marketing in dental surgeries. Participants felt that a greater visible presence would increase their likelihood to go to GDC and draw on the information it supplies.

Understanding of the language used by the GDC was relatively good though, when tested in the qualitative interviews. Participants were generally confident in their understanding of terms such as “fitness to practise” and “struck off”. However they were less confident about the term “erasure”, and thought that this needed clearer language or further explanation .

Participants also discussed the name of the GDC as part of the qualitative interviews and generally thought it was appropriate and meaningful. They were not keen for it to be changed, though they emphasised the importance of clear supporting information in any materials to explain exactly the scope of the organisation.

Satisfaction with dental care

Patient satisfaction with dental care is high, with 96% of those who visit their dentist at least once a year satisfied with the care received. Those from ethnic minority backgrounds are slightly less satisfied than others, with 41% of ethnic minority people saying they are *very* satisfied compared to 63% of white people. The most common reason given for satisfaction is the professionalism of the dentist, and the qualitative research showed that patients judge professionalism in terms of the manner of the dentist and their ‘softer skills’. Technical skills featured less heavily as it was thought more difficult to judge this aspect of care. On the other hand, poor quality treatment does lead to dissatisfaction, suggesting that the more technical or clinical aspects of care are only noticeable when they are absent or lacking in some way.

On the whole, patients are also positive about the information provided to them at their dental practice. For example, over three in four patients say that the dentist discussed options for treatment with them (78%), gave them enough information about treatment options (78%) and allowed them sufficient time to make a decision (77%) at their last visit. However, patients are less positive about the pricing information on display (41% agree that there was a simple list on display) and information about GDC regulation (34% agree that this was on display).

Attitudes to regulation

In line with the findings in 2012, confidence in dental regulation is slightly higher than confidence in regulation in general and in healthcare. Almost eight in ten people (who are

aware of the GDC) are confident that the GDC is regulating dental professionals effectively (77%). The corresponding proportion for healthcare and general regulation is around seven in ten, as it was in 2012 (70% and 71% respectively).

The findings from the focus groups suggest that where patients are aware of news stories relating to poor dental care, they are more likely to place an importance on regulation and the GDC, as they believe that closer scrutiny is needed.

The complaints process

As was found in 2012, few people have complained or even considered making a formal complaint about a dental professional. Again, a significant minority of patients who complained or considered complaining say they did not know to whom they should complain (27%).

A number of trigger points emerged from the focus groups; motivation to complain tended to depend on a combination of the severity of the event and whether it was repeated or a one off incident. However, participants also showed concern about knowing when an incident was sufficiently serious, and how to make a complaint.

Choosing a dental practice

Patients are most likely to choose a dental practice based on its location (44%) and on the basis of personal recommendation or experience. The qualitative interviews revealed that they would expect a number of factors to influence whether a practice was recommended by a friend or family member, though they would not specify these in their conversations (e.g. the quality of care provided, the manner and professionalism of the dentist, the cleanliness of the practice and the cost of treatment).

Just one per cent says that they have checked whether the dental professionals treating them have had any disciplinary action taken against them. The qualitative interviews showed that this did not occur to people, as they assumed that a professional would not be allowed to practise if there were serious concerns about them.

The introduction of a star rating system receives some support; almost three in four say that this would be useful in choosing where to go for dental care (72%). While participants in the interviews and focus groups welcomed the idea, there was no consensus around how it might work. Participants in the qualitative interviews emphasised the importance of personal recommendation over an official rating. As such, they thought that patient feedback or reviews were an important component of any rating system. In addition to being a tool for

patients to use when choosing a new practice, they noted the potential value of a star rating system in improving standards for all patients.

Dealing with poor care or wrongdoing

While the public express confidence in dental regulation and the GDC (as noted earlier), there is some uncertainty about whether appropriate action will be taken to address specific cases of poor care or serious wrongdoing. For example, around four in ten people say they are not confident that the regulator would take appropriate action to deal with repeated overcharging of patients or poor care being delivered to residents in a care home or disabled patients (40%, 41% and 38% respectively).

The qualitative interviews and focus groups revealed that there was some uncertainty over whether action should be taken in these situations, depending on the frequency of the problem occurring and the intention of those involved. If poor care was being provided intentionally, then this should result in significant disciplinary action, particularly in the case of the vulnerable populations used in the examples. Otherwise they felt that training should be considered as a preferred alternative.

There is slightly more confidence that health and dental regulators (and the NHS) share information between each other so that they can investigate poor treatment. Almost two in three think this happens (64%).

Providing an explanation

There appears to be faith in action taken by dental professional when something goes wrong, with almost seven in ten (69%) saying that they think a dentist would provide an explanation. Where dental professionals fail to provide an explanation, the survey shows that the vast majority of the public feel that they should be disciplined by the professional regulator (82% said they should be disciplined). Interestingly, those from ethnic minorities are more likely than their white counterparts to think both that dental professionals are unlikely to provide an explanation (57% vs. 71%) and that the response to dental professionals not providing an explanation should be ‘nothing’ (17%vs 4%).

Cosmetic dentistry

The vast majority of patients believe that cosmetic dentistry should only be carried out by dental professionals (87%) and that there should be clear and accessible information available about who is qualified for this purposes (89%).

Specialists

As seen in relation to healthcare in general, the vast majority of people say they would prefer to be referred to a specialist by their dentist (80%) than finding a specialist themselves (6%).

Overseas dental professionals

Around half of the public believe that dental professionals are tested to ensure they are fluent in English (53%) and that those who have qualified overseas receive training about how dental patients expect to be treated in the UK (52%).

Dentistry as a business

Two in five people believe that dental professionals put their own profit before the needs of their patients (39%). The participants in the qualitative interviews acknowledged that this was a potential issue, but none had experienced it themselves. They tended to think that there could be pressure on dentists to recommend more expensive treatments that were unnecessary in order to make money. While it is arguable that a degree of profit motivation is good in dentistry as it encourages innovation and improved services, respondents did not readily see the potential benefits of being profit-led.

Dental patients as consumers

The discussion groups provided an opportunity to explore dental patients' attitudes and behaviour in more depth. Participant's current attitudes could be described as existing on a continuum from a more traditional outlook (with less stated propensity to take action such as complain or change dentist), to a more consumerist outlook (being more pro-active and demanding). It was common for participants to have a mixed outlook that could change according to the circumstances.

Participants believed that patients are becoming more demanding. They suggested three factors that could encourage patients to take a more consumerist and proactive approach. These were experiencing a change of circumstances, receiving poor quality care, and the wider environment in which dental professionals work. Each of these factors provides GDC with potential opportunities to support and facilitate more consumerist behaviours amongst patients.

Introduction

1.1 Background and objectives

Background

This report contains the findings of a quantitative survey of the general public carried out by Ipsos MORI on behalf of the General Dental Council (GDC), supported by qualitative interviews with a small number of people who participated in the quantitative survey and six qualitative focus groups with the general public. As an organisation independent of the National Health Service (NHS) and Government, the GDC is responsible for regulating dental professionals in the UK. All dental professionals are registered with the GDC, whose aim is to protect the public and patients and regulate the dental team.

Research objectives

The key objectives of the research were as follows:

- To track how opinions have changed for a set of baseline questions that were asked in the previous Annual Surveys in 2011 and 2012.
- Capture and compare public and patient awareness and perceptions of the GDC and its performance and impact in fulfilling its regulatory roles and responsibilities;
- Obtain public and patient insight into key policy initiatives being developed by the GDC;
- Test public views and understanding of topical or current issues in dentistry / dental regulation; and
- Identify emerging policy issues that are relevant to the GDC.

As in 2012, a **qualitative** research element is also included here. Following the quantitative survey, 11 in-depth telephone interviews were carried out to explore some of the topics in greater depth and gather further insights into underlying attitudes.

This research wave also involved six qualitative focus groups with the general public[1]. As with the in-depth telephone interviews, the purpose of the focus groups was to explore some

[1] In total 55 individuals took part in the focus groups.

of the topics of the quantitative survey in greater depth. In particular, they were used to explore consumerism in dental choice in more detail.

About Ipsos MORI

Ipsos MORI is an independent social and market research agency working in accordance with the Market Research Society code of conduct[2]. As such, Ipsos MORI's work conforms to industry standards of impartiality, independence, data protection, and information security. The conduct of the research and the findings in this report are therefore not influenced by the GDC in any way, nor does the GDC have access to any of the personal responses of people who participated in the research.

1.2 Methodology

About quantitative and qualitative research

This research project employed both quantitative and qualitative methods.

The purpose of quantitative research is to determine conclusively what any given population thinks about certain issues (in this case a representative sample of the general public was interviewed). From a quantitative survey we can therefore say what the general population thinks, subject to certain margins of error. In order to ensure margins of error are not too broad, a quantitative survey of the general public will typically involve interviewing a large sample of people. Each person will be interviewed in the same way (in this survey interviewers spoke to people face to face), with the interviewer adhering strictly to a pre-agreed questionnaire.

Qualitative research, on the other hand, is not meant to be representative or to produce definitive conclusions. It is, rather, useful for exploring nuances in people's opinions and their motivations. It is ideal for exploring issues in depth, something that is not possible to do in a quantitative survey where interviewers cannot deviate from the questionnaire. As such, qualitative research discussions tend to be open-ended and free-flowing, based around a number of broad themes or topics.

Typically, qualitative research involves speaking to much smaller numbers of people than quantitative research. There are a variety of qualitative research methods, including focus or discussion groups, and in-depth one-to-one interviews, either face to face or by telephone. This project involved telephone in-depth interviews.

[2] http://www.mrs.org.uk/standards/code_of_conduct/

About this research

The research was structured in two complementary phases: the quantitative survey took place first, between 26 September and 7 October 2013, followed by the qualitative research, which involved in-depth interviews undertaken between 28 October and November, and focus groups conducted between 9 and 11 December. The qualitative research enabled us to explore in more depth some of the nuances, motives and thought processes that may be behind the survey results.

Quantitative survey

The Annual Survey questions were placed on the Ipsos MORI Capibus survey, a weekly face to face omnibus survey of a representative sample of adults aged 15 and over in Great Britain. To achieve UK wide coverage for the survey, this was supplemented with an additional standalone survey of adults in Northern Ireland, which is not covered by Capibus. Extra Capibus interviews were also carried out in Wales to ensure at least 100 interviews there. This meant that sufficient interviews were completed within each of the UK nations to provide more statistically robust results within each nation. Ipsos MORI and the GDC worked together to develop the survey questionnaire. A key part of this work was the cognitive testing[3] of the questionnaire with members of the public prior to the start of fieldwork. A detailed summary of cognitive testing findings was shared with the GDC and fed into the subsequent finalisation of the questionnaire.

Fieldwork took place between 27 September and 07 October 2013. A total of 1,501 people were interviewed via Capibus in Great Britain, with 102 also interviewed in Northern Ireland, giving a total sample size of 1,603.

Quantitative data

Quotas were set and data weighted[4] to ensure a nationally representative sample of adults aged 15 and over in Great Britain and Northern Ireland. This included down-weighting the additional interviews carried out in Northern Ireland and Wales. Quotas were based on age, gender and working status within region. Throughout the report findings will highlight, and

[3] The purpose of cognitive testing is to explore how well, precisely, and consistently questions are understood by the participant; and to ensure the questions are eliciting the required information.

[4] When data collected from survey respondents are adjusted to reflect the profile of the actual population, this is called weighting. For example, in this survey, the proportion of interviews conducted in Northern Ireland was greater than the proportion of UK residents who live in Northern Ireland. In the overall results the Northern Ireland interviews are therefore 'down-weighted' i.e. each interview in Northern Ireland is given less weight in the overall results than an interview in England, for example.

make reference to, different subgroups based on responses to certain questions.[5] When interpreting the survey findings, it is important to remember that the results are based on a sample of the population, not the entire population. Consequently, results are subject to margins of error, and not all differences between subgroups are statistically significant (i.e. a real difference). For example, for a question where 50% of the people in a weighted sample of 1,603 respond with a particular answer, the chances are 95 in 100 that this result would not vary more than plus or minus two percentage points from the result that would have been obtained if the entire population was asked (using the same procedures). The margins of error for the smaller base sizes in the survey (i.e. questions which were asked to only a proportion of the overall sample) are indicated in Appendix A on statistical significance.

Caution should be exercised when comparing percentages derived from base sizes of 99 respondents or fewer, and particularly when comparing percentages derived from base sizes of 50 respondents or fewer. In the reporting that follows, percentages which derive from base sizes of 50-99 respondents should be regarded as indicative and are flagged as such.

Qualitative in-depth interviews

Eleven people, who had taken part in the quantitative survey and expressed a willingness to take part in a further qualitative interview, were interviewed by telephone. The qualitative interviews lasted 45 minutes on average.

Participants in the qualitative interviews were selected to be broadly reflective of the general population in terms of age, gender and social grade. They were also recruited to reflect a range of attitudinal factors expressed in answers given to certain questions in the Annual Survey. A full breakdown of the qualitative in-depth interview sample can be found in Appendix D.

That said, it should be remembered that the small numbers involved mean that qualitative research is not able to provide a representative picture of the views of the wider population. Rather, the aim of this element of the research is to explore views and opinions in-depth in a way not possible in the format of a quantitative survey.

Qualitative focus group discussions

While the qualitative in-depth interviews allowed for detailed insight on individuals' views, additional focus groups were undertaken to explore further some of the themes which came out of both the quantitative survey and qualitative interviews in a more flexible and creative

[5] The data tables with full details of all results by stratification are available on the GDC website: http://www.gdc-uk.org/Pages/default.aspx

environment, By using focus groups it was possible to hear reflexive views and deeper justifications as participants discussed ideas and challenged each other's opinions.

In total six focus groups lasting an hour and a half were conducted with the general public in London, Nottingham and Glasgow. A total number of 55 people participated, with around 8-10 people present in each group.

As with the in-depth interviews, participants were selected to reflect the general population in terms of age, gender and social grade. All participants had visited a dentist within the last two years but were then (as with the in-depth interviews) recruited to reflect a range of attitudinal factors expressed in answers from the Annual Survey. In particular, participants were recruited to reflect a range of attitudes around approaches to choosing a dental practice termed as adopting a consumerist approach, (i.e. more willing to 'shop around' or expect more from the service received) or a more traditional approach. See breakdown below.

Date	Location	Age	Consumer vs. traditional
9th December	London	Younger	Consumer
9th December	London	Older	Mix
11th December	Nottingham (rural)	Younger	Traditional
11th December	Nottingham (rural)	Older	Consumer
11th December	Glasgow	Younger	Mix
11th December	Glasgow	Older	Traditional

As with the findings of the in-depth interviews, the small number of participants and the qualitative nature of this research method means that the results can only give insights into general views and should not be seen as representative of the whole population,

1.3 Public and patient use of dental professionals

The introductory questions in the survey sought to establish the characteristics of the sample in relation to their use of dental services. These characteristics can be summarised and compared with the previous survey as follows:

- **Last visit to the dentist:** Two thirds of people (66%) have visited the dentist in the last 12 months, and three quarters (76%) have been to the dentist within the last two years. Four per cent says they have never been to the dentist. These are almost

identical to results from 2012 and 2011; the main shift is a decline in those who say they have 'never been' to the dentist from 7% in 2012, returning to a similar level to that recorded in 2011 (3%).

- **Frequency of visits to the dentist:** One in two (54%) visits the dentist on average once every six months. Again this is comparable to the 2012 result, where 52% visited once every six months on average.

- **Length of time with current dentist or dental practice:** While in 2012 it was reported that half (50%) of all patients remained with their dentist for five years or less, in 2013 just four in ten (40%) did so, with the majority staying with their dentist over five years (58%). Among these, almost a fifth of patients (18%) have been with their dentist for over 20 years.

- **Private vs. NHS care:** As in 2012, the survey records around three-quarters of patients having received NHS treatment, either paid-for (48%) or free (24%), at their last visit to the dentist. However, it is notable that this year the proportion of those receiving paid-for NHS care has increased +3 percentage points, and those accessing free NHS care has declined -7 percentage points compared with the 2012 figures. The proportion receiving private dental care is similar (20% compared with 18% in 2012). Although a similar question was asked in 2011, the wording was changed in 2012 and as such the data is not strictly comparable.

- **Treatment by dental care professionals other than a dentist:** There has been a marked increase in patients receiving dental treatment from a professional other than a dentist; from 27% in 2012 to 37% in 2013. Of these, the majority (77%) of appointments were with a dental hygienist; in 2012 this was also the case (72%)[6].

- **Frequency of appointments with other dental care professionals:** People who have had an appointment with a dental hygienist tend to see them at least once a year (56% in 2013). This has dropped slightly since 2012 when 62% of people who had an appointment with a dental hygienist saw them at least once a year.

Full details of these questions including charts can be found in the Appendices.

[6] In March 2013 changes to 'Direct Access' standards were introduced by agreement by the GDC, giving patients the option to see a dental care professional (DCP) without having first seen or obtained a prescription from a dentist. This may explain why the 2013 survey sees a greater percentage of individuals saying they have received dental treatment from a professional other than a dentist. For more information on 'Direct Access' see:
http://www.gdc-uk.org/dentalprofessionals/standards/pages/direct-access.aspx

1.4 About this report

The topics covered in the quantitative and qualitative aspects of the research were as follows:

- Awareness and understanding of dental regulation and the GDC;
- Satisfaction with dental care;
- Attitudes to regulation;
- The complaints process;
- Choosing a dental practice;
- Perceptions of good practice and dealing with poor care and wrongdoing;
- Topical policy issues; cosmetic dentistry, dental specialists and dentistry as a business; and
- Consumerism in dental choice.

The structure of the report mirrors these topics, presenting the quantitative and qualitative findings together. The main focus of the report is on the quantitative analysis, with material and *verbatim* quotes from the qualitative research where they add insight and extra depth to the quantitative findings. Chapter 9 on consumerism focuses only on findings from the focus groups. The final chapter draws together the main themes into conclusions for the GDC to consider.

Topline findings from the survey and copies of the discussion guide used in the qualitative interviews and focus groups can be found in the Appendices. Full data tables will be published and made available on the GDC's website.

1.5 Acknowledgements and publication of the data

We would like to thank Amanda Little and Guy Rubin at the General Dental Council for their support and advice throughout the project. We would also like to thank all the members of the public who took part in the quantitative survey, especially those who also took part in the subsequent qualitative interviews.

As the General Dental Council has engaged Ipsos MORI to undertake an objective programme of research, it is important to protect the organisation's interests by ensuring that it is accurately reflected in any press release or publication of the findings. As part of our

standard terms and conditions, the publication of the findings of this survey is therefore subject to the advance approval of Ipsos MORI. Such approval will only be refused on the grounds of inaccuracy or misrepresentation.

2. Awareness and understanding of dental regulation

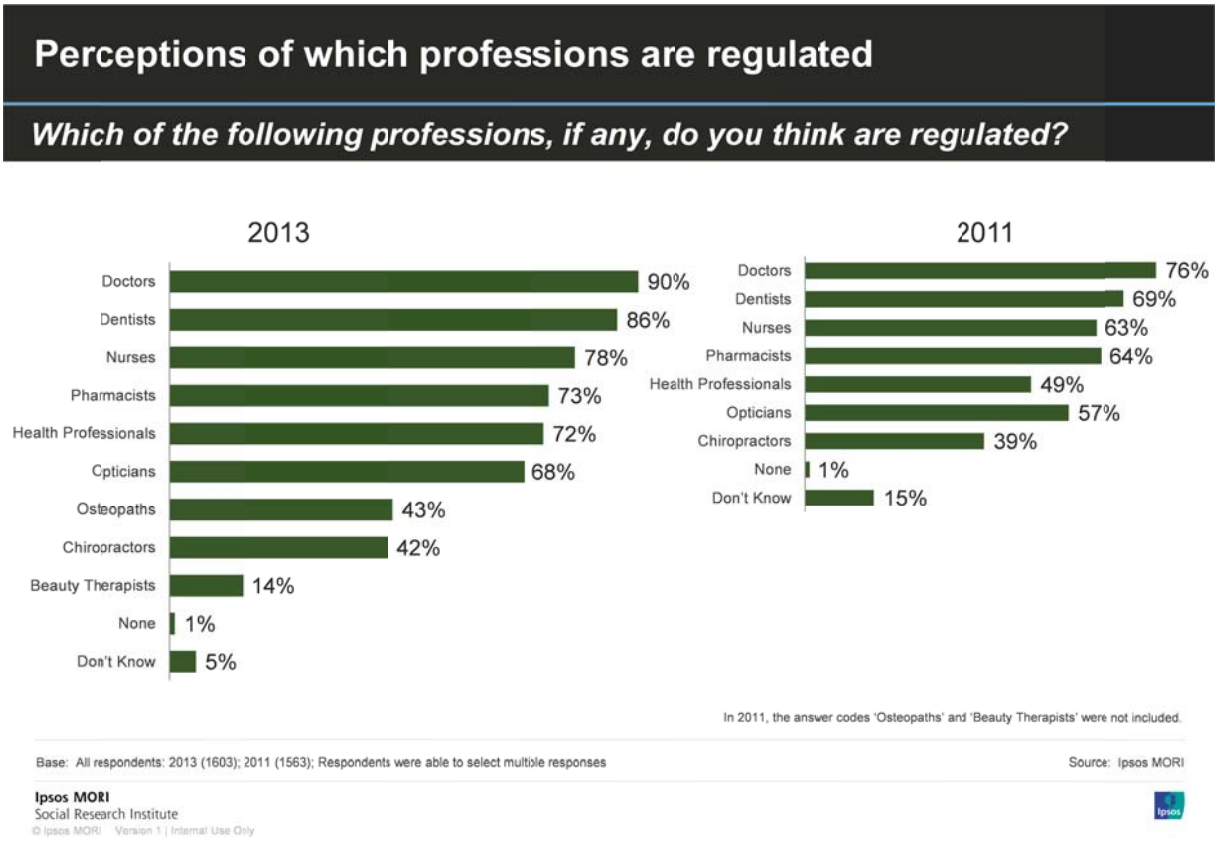
This chapter explores public awareness of the GDC, and their understanding of various aspects of dental regulation.

2.1 The regulation of dental professionals

Regulation of professional healthcare groups

It appears that the public is aware of regulation amongst a range of healthcare professions or at least expects them to be regulated. When given a long list, a large majority of people correctly identified those working in a regulated field and just 14% identified beauty therapists who are not regulated.

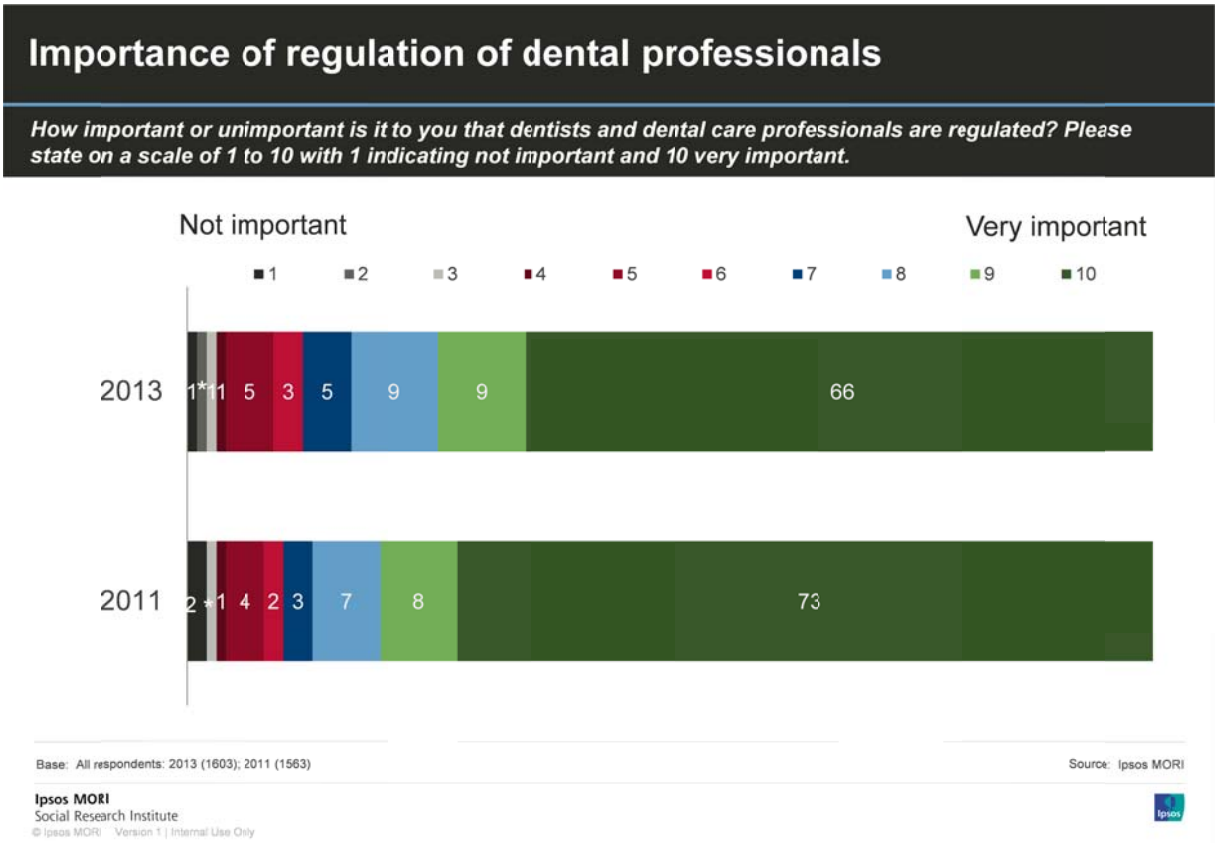
Almost nine in ten (86%) identified dentists as subject to professional regulation, slightly fewer than the 90% mentioning doctors. While there appears to have been a significant increase in those saying dentistry is regulated; (up from 69% in 2011), this is true for all the professions presented to respondents. This may be as a result of high profile news stories regarding regulation. However, questionnaire ‘order effects’ may also have had a role to play. In 2013, the question followed two other questions about regulation, whereas no questions about regulation preceded the question in 2011. The respondents in 2013 may have been more primed to think about the concept of regulation in this year’s survey than two years ago therefore.



The focus groups showed a general assumption amongst participants that dentists would be regulated, rather than certain knowledge of the fact. This tended to be based on the fact that they knew that other professions such as doctors were.

Importance of regulation for dental professionals

The regulation of dental professionals is generally seen to be important. Two thirds (66%) indicate that regulation is very important by attributing a score of 10 (on a scale of 1 to 10). This is slightly less than in 2011, when almost three quarters of people gave a score of 10. Just three per cent give a score of less than 5 in 2013.



The mean score (i.e. the average score across all respondents is 9.0). Comparison across different groups shows that regulation is most keenly supported by women (mean = 9.15); those in social grade A[7] (9.46) and B (9.27); white people (9.12); residents in Northern Ireland (9.57) and the south of England (9.18). Perhaps not surprisingly, it is particularly more pertinent to those who visit the dentist at least once a year (9.28) compared to those who go less often (8.78).

The findings from the focus groups suggest that the prevalence of news stories in the local area concerning dental malpractice had a significant impact on participants' views. Those who were aware of these news stories were also aware of the regulation of dentists and were better able to articulate their expectations of regulation. Indeed, in Glasgow a number of respondents made reference to recent news reports they had read about dentists who had had action taking against them as a result of malpractice[8]:

[7] The social grade definitions used in this report are standard on surveys carried out by Ipsos MORI and used by the Institute of Practitioners in Advertising. They are defined as follows: A (higher managerial, administrative or professional), B (intermediate managerial, administrative or professional), C1 (supervisor or clerical and junior managerial, administrative or professional), C2 (skilled manual workers), D (semi and unskilled manual workers), E (state pensioners, etc, with no other earnings).

[8] At the time of the focus group two prominent stories about dentistry in Glasgow had been in the news; one involving unlicensed dentists and another about a dentist with HIV:

> ***"……it was a dental practice. It came on the news that they were wrecking teeth and they had to stop practising"***
>
> (Participant in Glasgow group, younger mixed)

Participants in Glasgow stressed a much greater perceived need for the regulation of dentistry, detailing specific areas of dentistry they were concerned about, than participants in other areas who largely talked more generally about the importance of regulation:

> ***"I think especially in this day and age as well as the amount of treatments that are available to people in the UK now as opposed to 15 or 20 years ago, with teeth whitening and all the different things that you can get done, it's even more important now that you've got a regulatory body there that's keeping an eye on these things because it can be quite horrific."***
>
> (Participant in Glasgow group, younger mixed)

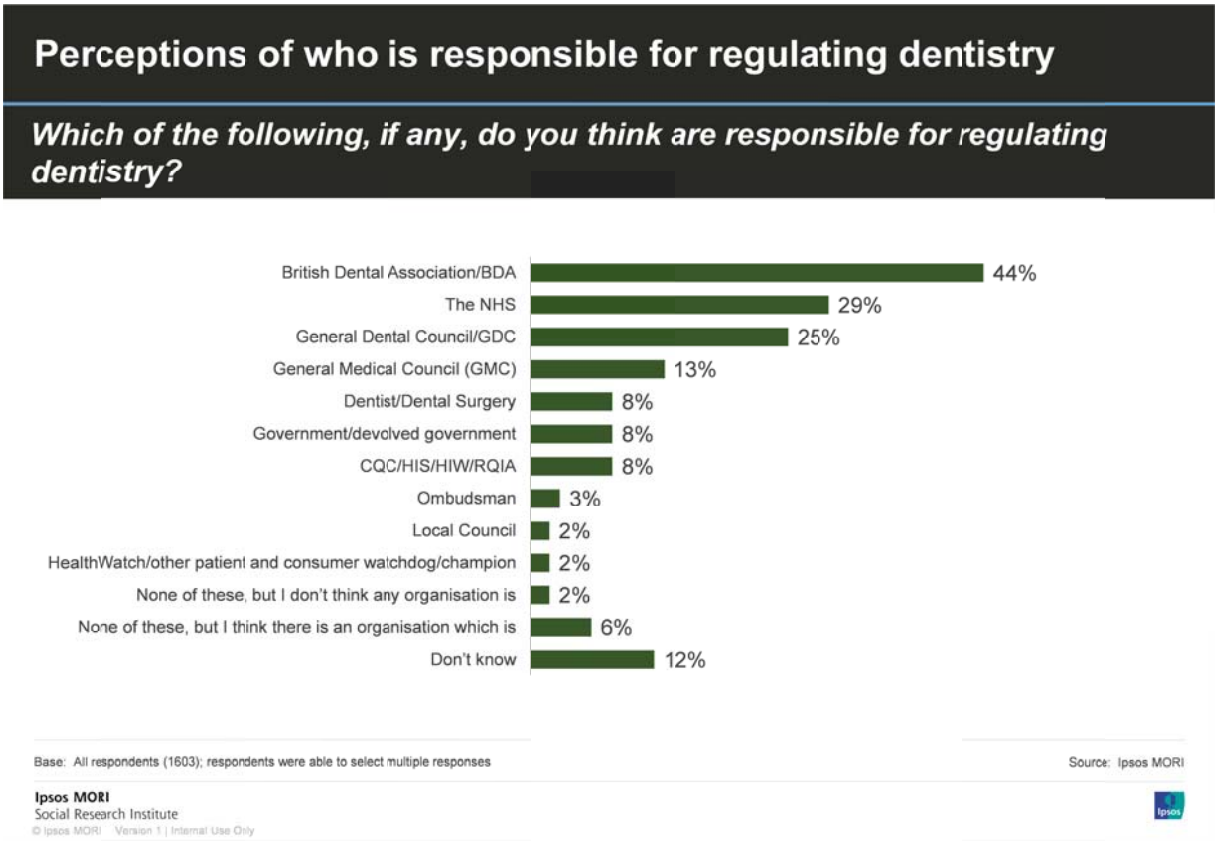
---

http://www.scotsman.com/news/health/scottish-dentist-suspended-over-grave-failings-1-3147341 and http://news.stv.tv/west-central/236587-hiv-dentist-at-paisleys-kelburne-surgery-leads-to-nhs-campaign/

2.2 Awareness of the GDC

Responsibility for regulation

When given the option to select one or more organisations responsible for regulating dentistry from a pre-established list, one in four (25%) people say they think the GDC is responsible for regulating dentistry; this is the third most mentioned organisation[9]. Above the GDC in the ranking are the British Dental Association (44%) and the NHS (29%). Over ten per cent (13%) also thought this is the responsibility of the General Medical Council, while fewer cited other government and health bodies.

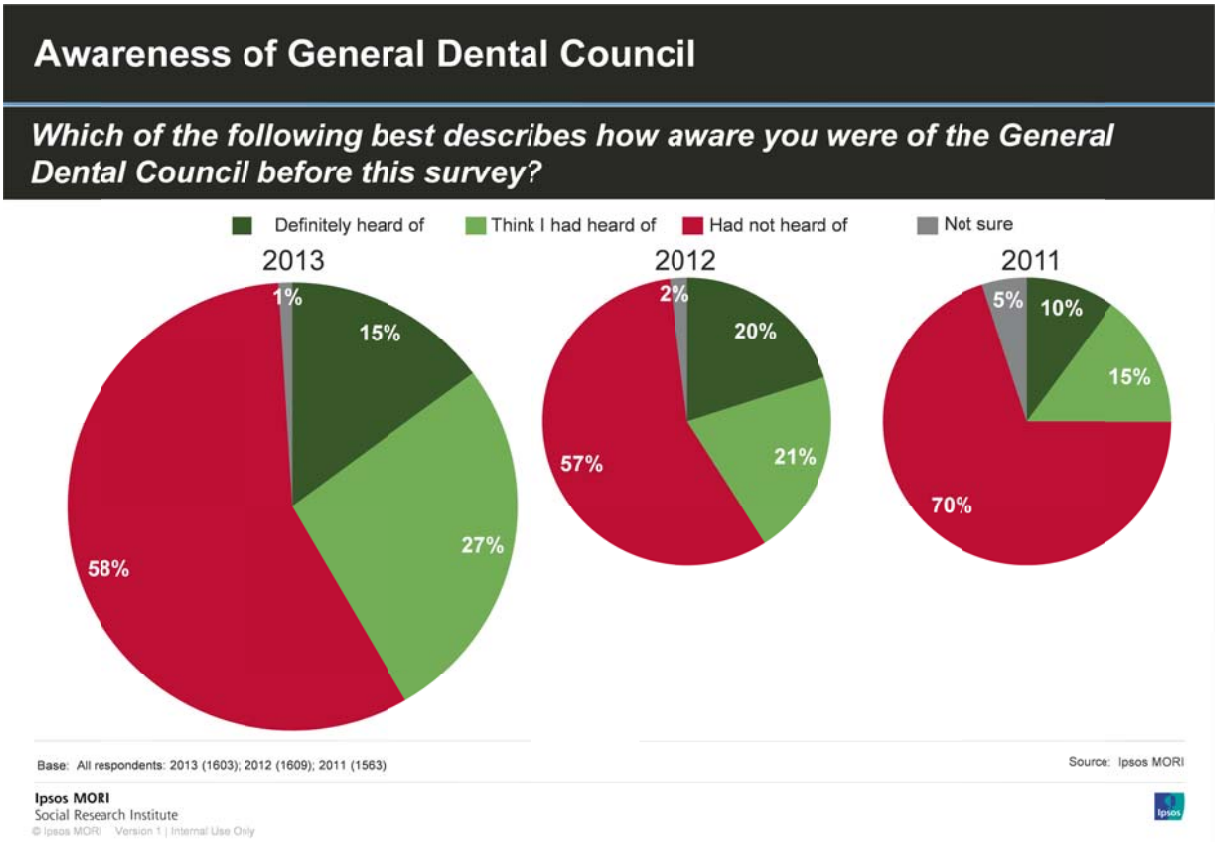


Prompted awareness of the GDC

Awareness of the GDC improved significantly between 2011 and 2012, so that one in five people last year said they had definitely heard of the GDC (20%). This has now fallen in 2013 to 15%. However, the proportion saying they have not heard of the GDC before the survey was carried out (58%) remains in line with the finding in 2012 (57%). This year,

[9] This was the first point in the interview where respondents were presented with the name of the GDC.

people are more likely to say they **think they have heard** of the GDC (27% vs. 21% in 2012).

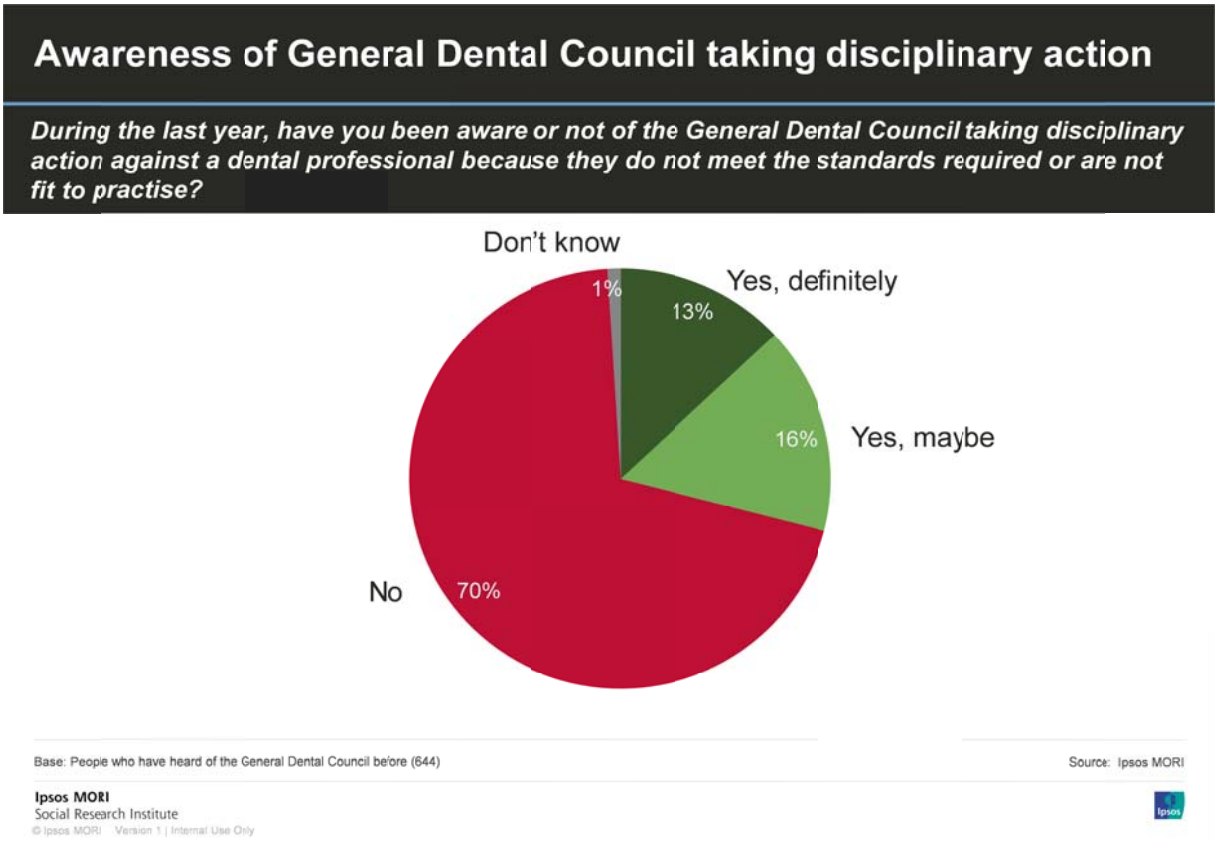


There are a few key factors which appear to be linked to reported awareness of the GDC. Age is important, with younger people much less likely to have heard of the GDC than older groups (4% of those aged 15-24 have definitely heard of the GDC vs. 23% of 55-64 year olds and 21% of those aged 65 and over). There are also differences by social grade; one in four people in social grade A and one in five in social grade B had heard of the GDC before the survey (26% and 19% respectively vs. 15% on average), while two thirds of those in the combined social grade C2DE had not heard of the GDC before (65% vs. 58% average). There is also a difference in terms of ethnicity (15% of white people have definitely heard of the GDC compared with 9% of people of ethnic minorities).

Those groups with higher awareness are also those who visit the dentist more regularly, which may reflect the greater number of opportunities they have to encounter GDC communications or who take a greater interest in their dental health.

Disciplinary action

The vast majority (70%) of people who have heard of the GDC are not aware of the GDC taking disciplinary action against a dental professional. Among those who have some awareness of disciplinary action, most are tentative (16% say maybe).



There are no significant differences by demographic groups, although national differences are again apparent. In Northern Ireland and Scotland more people tend to say they are *definitely* aware that the GDC has taken disciplinary action against a dental professional, (29% and 24% respectively) which contrasts sharply with the 81% in the South of England who said they are not aware of any such action.

As mentioned earlier, the focus groups showed there to be a general assumption among participants that dentistry would also be regulated, although very few were aware of which organisation this was. Of those who had heard of the GDC, it was only in the vaguest of terms and on the whole these participants could provide only limited explanations of what the GDC does, usually saying they thought it had a regulatory role but unable to provide specifics. Once provided with information about the GDC, participants across all groups agreed that it was essential that patients should be made aware of its role. Consequently, a clear desire for more information about the GDC was shown, with agreement of the need for greater publicity around what the GDC does and a feeling that it should do more to raise its

profile in the public domain. They felt that this information should be readily and easily available, rather than patients having to seek out information themselves. Particularly, it was felt that there should be more information about the GDC posted in dental surgeries, as specified in the new standards:

> "***You want them to be visible"***
>
> ***"You need a point of contact to complain to and perhaps it should be advertised in the waiting room, you know, make it more that they [dental surgeries] have to display the contact details, web address and perhaps email address."***
>
> ***"So you see it on the way out after you'd had a bad experience and think oh yes this who I need to contact"***
>
> (Participants in the Nottingham group, under 40 mixed)

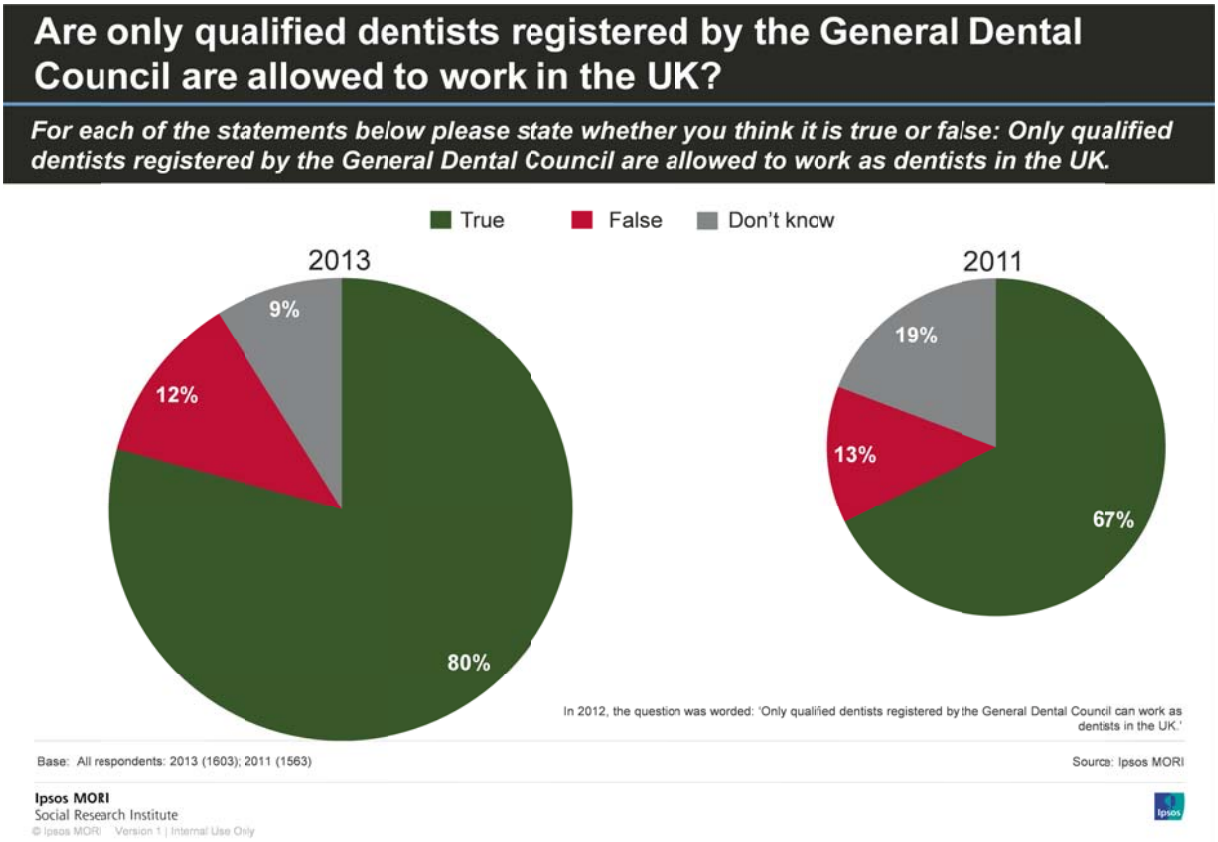
Where participants were asked, they overwhelmingly stated that they would prefer details of the GDC to be made available to them in the dental surgery with very few spontaneously saying via the internet. Some participants expressed concern that the internet is not readily available to all:

> ***"I think all this should be within the dental practice's waiting room because not everybody has a computer"***
>
> (Participant in Nottingham group, over 40 consumers)

2.3 Understanding of the GDC's registration role

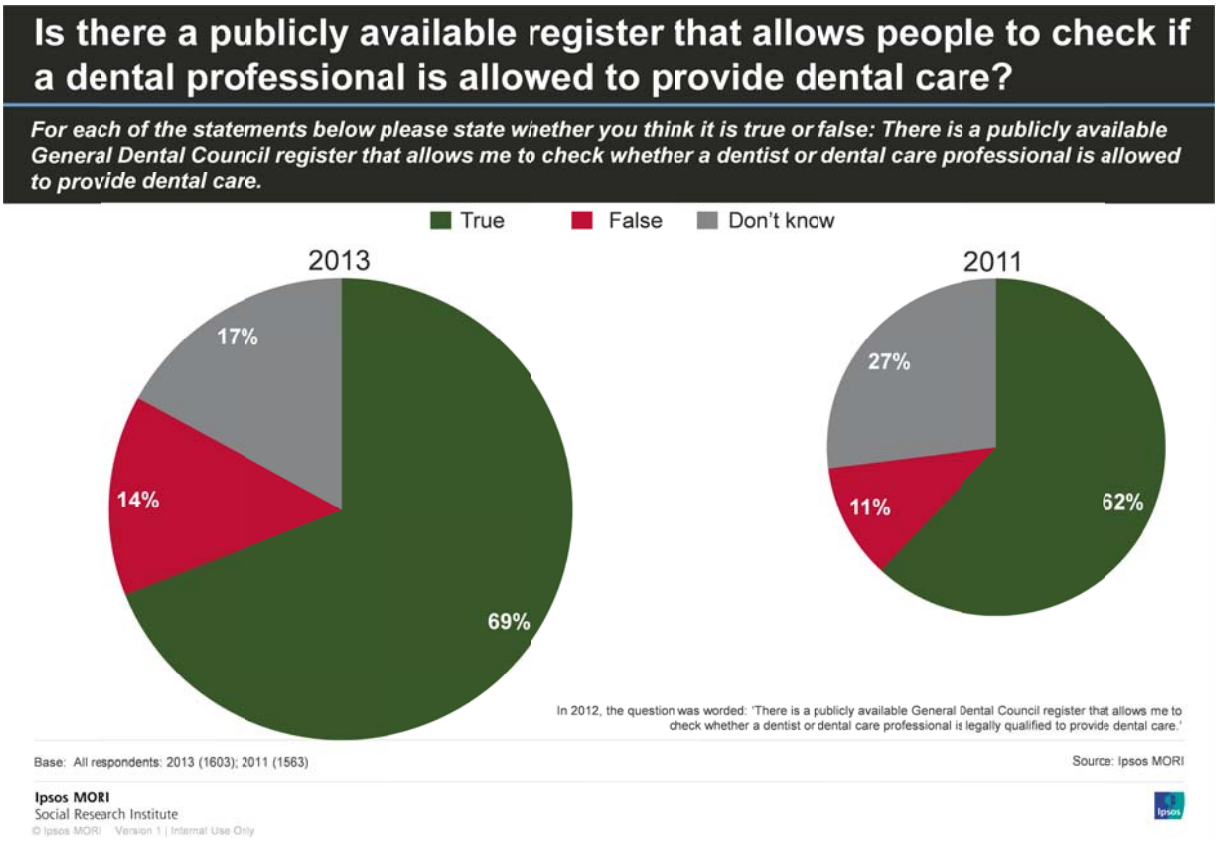
Criteria for registration

A large majority (80%) of people think that only qualified dentists registered by the GDC are allowed to work as dentists in the UK. While there has been an increase in the figure since 2011, this is likely to be linked to a change in the question wording and explanation provided to respondents.



Publicly available register of dentists

Over two thirds (69%) of people believe there is a publicly available GDC register that allows people to check whether a dentist or dental care professional is allowed to provide dental care. Almost one in five (17%) do not know. More people now believe this than in 2011 (62%), although it is possible that this reflects a change in the question wording[10].

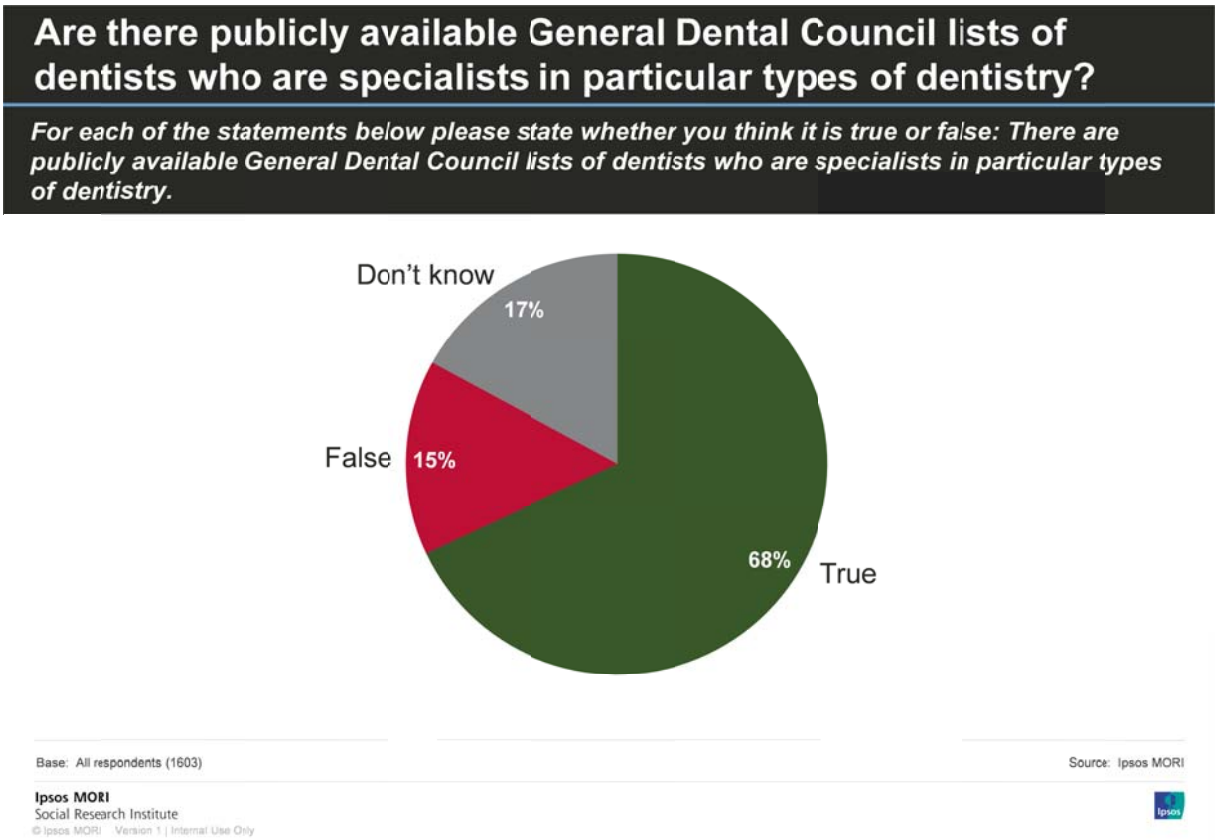


Those aged 15-24 (19%), in social grade E (24%), living in Scotland (20%), and of ethnic minorities (19%) are more likely to say this is not the case; the average is 14%.

[10] The phrase used previously was ... whether a dentist or dental care professional is *legally qualified to* provide dental care.

Publicly available list of dental specialists

Around two thirds (68%) of people believe there is a publicly available GDC list of dentists who are specialists in particular types of dentistry. Almost one in five (17%) do not know.



There are few differences by demographic groups, though notably women are more likely to believe this to be true than men (71% vs. 64% respectively). Those aged 65+ (25%) are most likely to say they 'Don't know' if this is the case.

2.4 Understanding of regulatory language

Understanding of technical terms used in disciplinary action

The qualitative interviews provided further opportunity to explore public understanding of the GDC and dental regulation. Participants were asked about their understanding of particular phrases that the GDC uses in its role as a regulator. This is particularly important for the GDC in its development of future communication materials.

Participants had different levels of understanding around these. In general those who had jobs where the same or similar phrases were used had the highest levels of understanding.

The individual terms are discussed below:

- **"Struck off"** was understood by all the participants taking part. It was a term they had heard regularly in the media and was thought to be in common use more widely;
- **"Illegal practice"** was broadly understood by most participants. Those who did understand the term associated it with regulations rather than criminal law. This may have related to the fact that the participants taking part had (to some extent) been informed about the role of the GDC through the questions in the survey and the early part of the interview.
- **"Fitness to practise"** was broadly understood by most of the participants with some explaining that they used the term in their jobs. However, there was some criticism of the word "fitness" with some believing the word was confusing as it was associated with being physically fit. For example, one participant who had been in the army explained that a soldier would be considered fit to practise if they were physically fit enough to go into combat. Some participants suggested that the terms "approved" or "capable" might be more helpful than "fitness", although others did not prefer these terms.
- **"Erasure"** was the term with more significant comprehension problems. In some cases participants worked out what the term meant after some time thinking about it, and or being presented with an example of its use in GDC communications. However, it was suggested that the term struck off would be more useful.

Understanding of the name "General Dental Council"

Participants were asked for their thoughts on the name of the GDC, specifically, whether they felt that it reflected the work that the organisation does. They generally agreed that name was reasonably helpful and should continue to be used. Some recognised the terms "General" and "Council" from the General Medical Council and assumed that the GDC has a similar role. The term "Council" is equated with authority and decision making, and participants associated this with the role the GDC has in deciding whether dental professionals are allowed to practise. There was less understanding of the use of the word "General" but it was not felt to be problematic. Some simply thought it meant that it covered all dentists.

> ***"You have a council in your town and they put down rules and laws that you have to stick by … and so you would think oh General Dental Council they are related in this way to dentists"***
>
> (Female/ Age under 45/ Social Grade C1)

Participants were asked about whether or not it might be possible for the wording of the Council's name to better reflect its role. Examples of other organisations whose names relate to their roles were discussed (such as 'Relate', an organisation that offers relationship counselling). However, participants thought the term "General Dental Council" was appropriate and sufficiently informative and there was not a strong desire for it to change.

Some participants questioned whether the GDC has a role in inspecting dentists[11]. They thought that the current name did not necessarily reflect this. They believed this could be achieved by using a descriptive tag line or by communications via traditional channels such as leaflets and posters in dental surgeries.

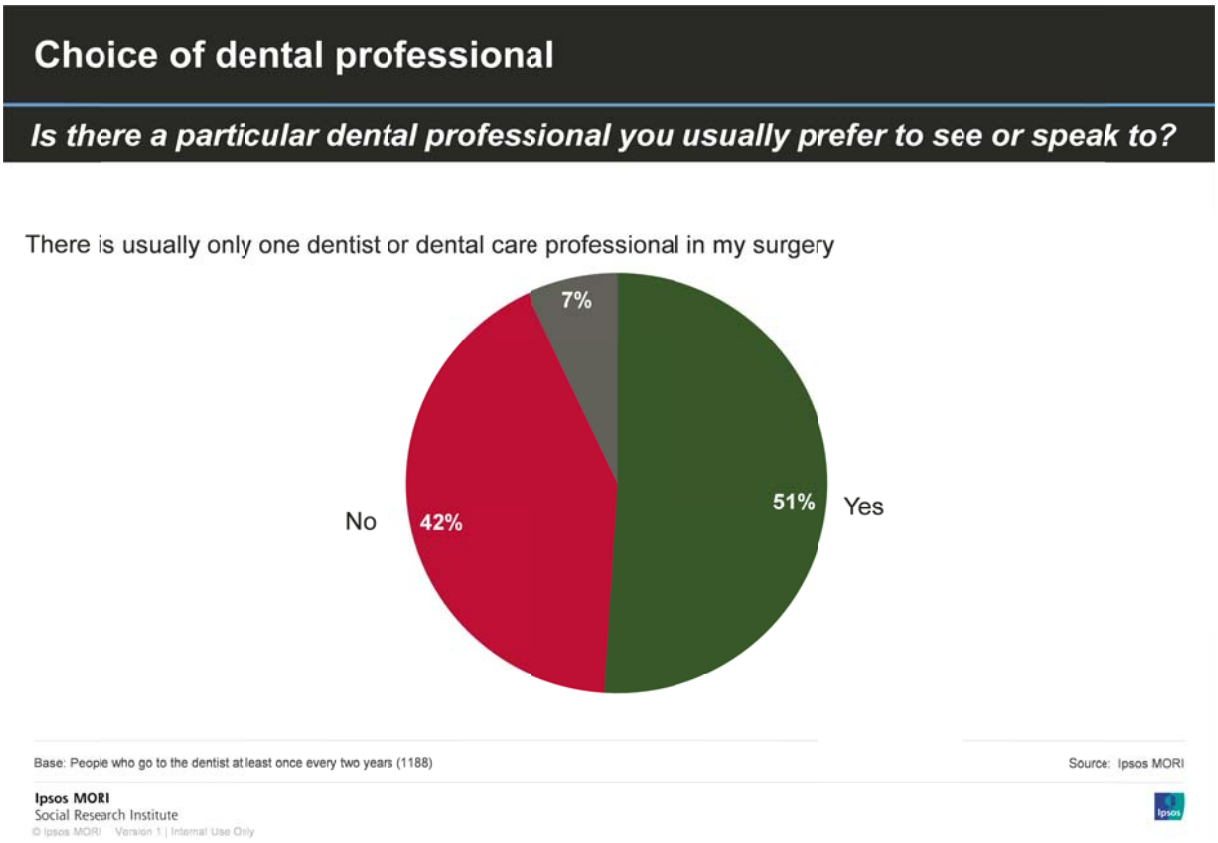
[11] The GDC currently does have an inspection role in quality assuring education.

3. Satisfaction with dental care

This chapter explores people's experiences of dental care, and in particular the reasons for their satisfaction or dissatisfaction with the care they have received.

3.1 Personal preference for a dental professional

Among those who say they visit the dentist at least once every two years, half (51%) prefer to see or speak to a particular dental professional. Two in five (42%) do not express a preference, however, and seven per cent say the practice they visit is run by a sole practitioner.

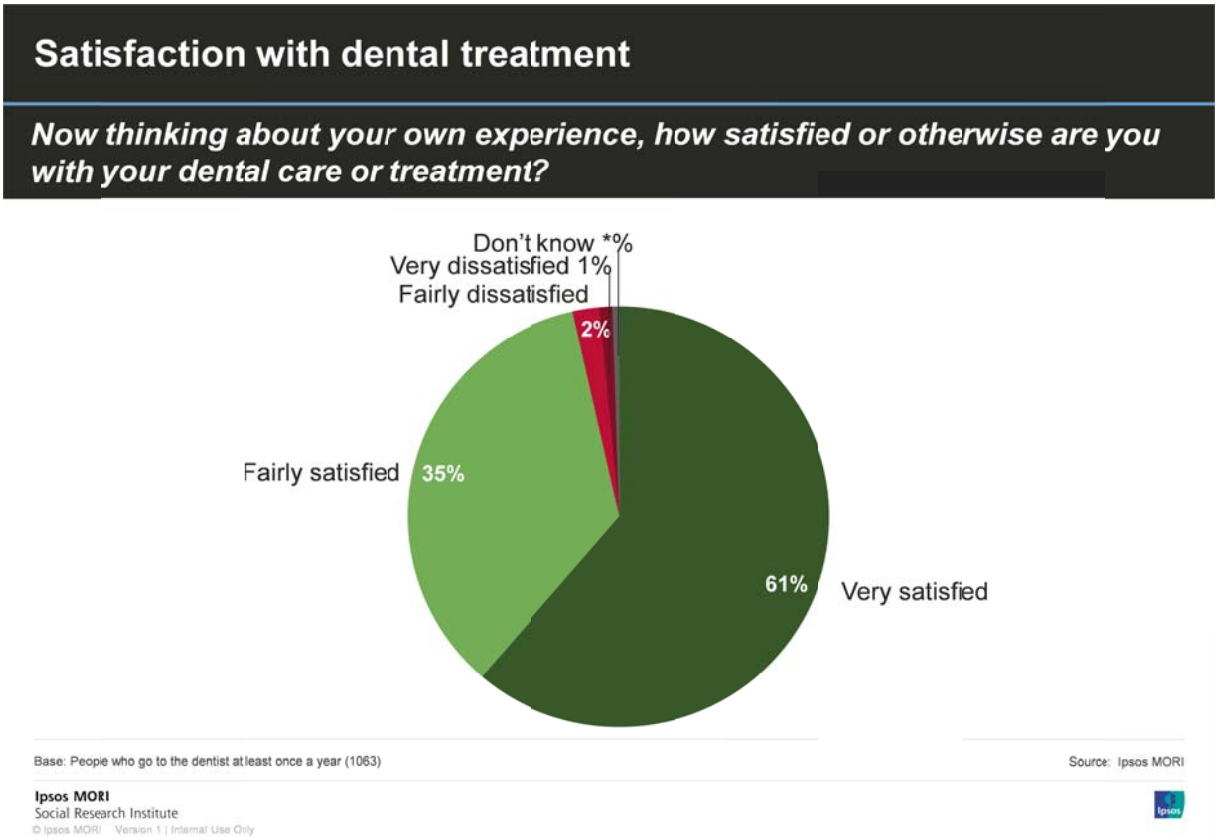


Certain groups of patients are more likely to prefer to see a particular professional. Those most likely to express a preference to see or speak to a particular practitioner include women (54%), those aged 55-64 (59%) and 65+ (64%) and those in social grade AB (60%). Those visiting the dentist at least once a year are also more likely to state a preference for a particular professional (54%).

3.2 Satisfaction with dental care or treatment

Satisfaction in general

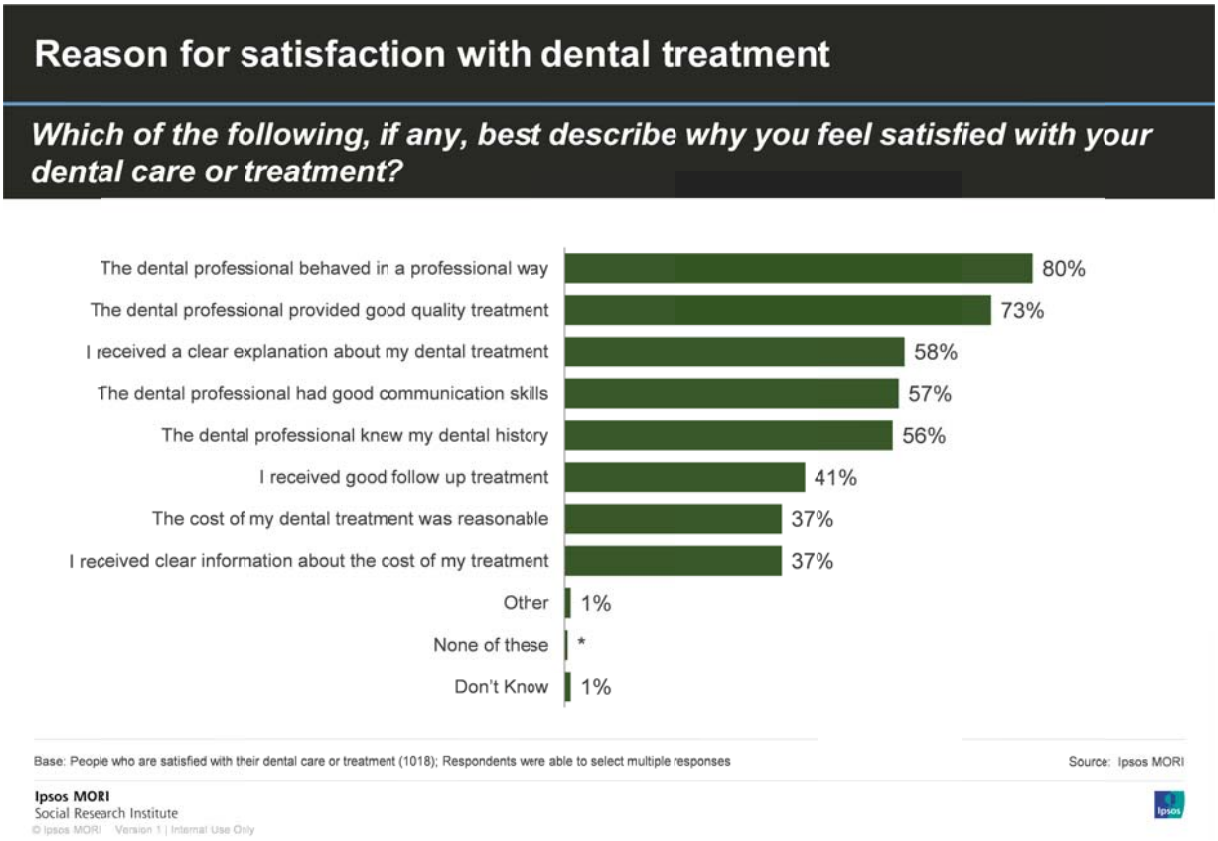
Patient satisfaction is high. The vast majority (96%) of people who go to the dentist at least once a year are satisfied with the dental care or treatment they have experienced, including six in ten (61%) who are *very* satisfied. Just three per cent (40 weighted respondents) overall say they were dissatisfied.



There are few sub group differences, given this high level of overall satisfaction. However, it is notable that in London, a higher proportion of people are *fairly* rather than *very* satisfied (51% and 49% respectively), while in Northern Ireland a significant majority is *very* satisfied (83%). Ethnicity differentiates the response; 63% of those from a white background are *very* satisfied compared with just 41% among minority ethnic groups. Those receiving private treatment tend to be more highly satisfied than those receiving other types of dental treatment (78% *very* compared to an average of 61%).

Reasons for satisfaction

It is clear that the behaviour and competence of the dentist is crucial to the patient experience. The majority of people expressing satisfaction cite the fact that their dental professional had 'behaved in a professional way' as a reason for their satisfaction (80%)[12]. Other reasons given included good quality treatment (73%), receiving clear explanation about treatment (58%), good communication skills (57%) and knowing the patient's dental history (56%).



Participants taking part in the qualitative depth interviews and focus groups provided some understanding of what 'professionalism' meant to them. They suggested that they judged dentists' professionalism principally through their **soft skills** such as their ability to listen to patients, help them feel at ease, and avoid coming across as judgemental. This was particularly important for those who felt that they were not always in a position to judge dental professionals' technical skills. These were also raised as important factors when choosing a new dental practice (see chapter 6). Focus groups participants similarly referred to a 'good dentist' as having excellent communication skills, talking through the treatment they are having, being polite and treating them with respect.

[12] Respondents were provided with a list of possible reasons for satisfaction to choose from.

> *"My dentist is very, very good. He is very reassuring. I recommend him to anyone. I think it's about being honest and upfront"*
>
> (London group, younger consumers)

In addition, there was some importance placed on putting the needs of the patient first. For example, one participant talked of the trust she had in her dentist, and her faith that he would always recommend the right course of action for her. This was important given the potential cost implications of treatment.

> *"He's not recommending things on the basis of cost, but treatment that's most suited to me."*
>
> (Female/ Age 45 plus/ Social Grade B)

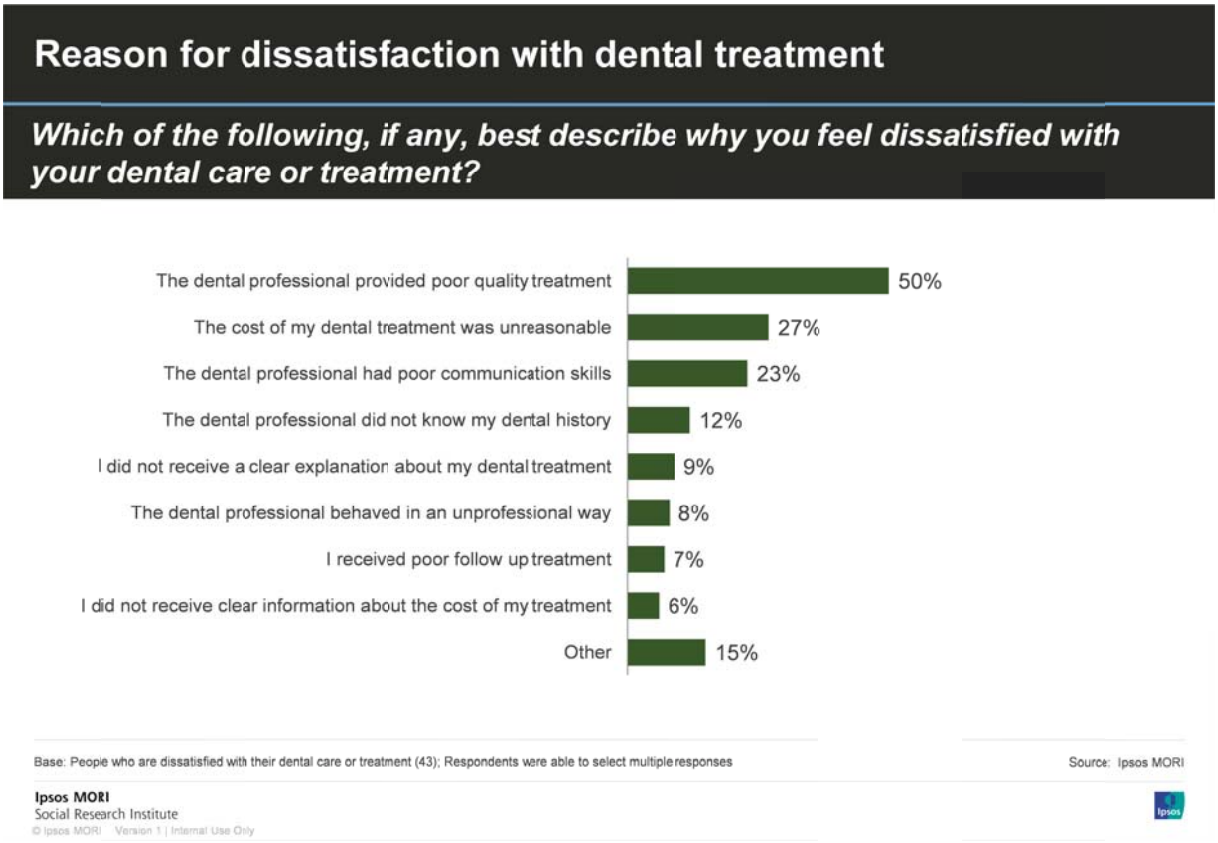
There were some participants who suggested that they could form an impression of dentists' **technical skills** through the work they did. For example, one participant explained that he would be concerned if a dentist seemed to be 'clumsy' as this could mean that the dentist might make a mistake. Another discussed how his dentist seemed to remove teeth very easily in a way that did not cause any pain, suggesting that she was skilled at her job.

> *"What we would expect from a dentist is a comprehensive examination of your mouth to see that your mouth is healthy … and to follow it with good treatment and explain to you why"*
>
> (Participant in Nottingham group, over 40 consumers)

There was little variation in the survey results between sub groups in terms of their reasons for satisfaction with care, except for between people in different countries. It seems that in the devolved administrations and Northern Ireland dental patients are more likely to mention the relational aspects of care including their dentist's knowledge of their dental history, communication skills, explanation given about the treatment and follow-up care than patients. Similarly, white patients are more likely to cite each of the aforementioned reasons compared with minority ethnic patients.

Reasons for dissatisfaction

Of the few who were dissatisfied (3%, 40 weighted respondents),when given a list of reasons for possible dissatisfaction with the dental care they had received, half (50%; 20 weighted respondents) say this was because their dental professional provided poor quality treatment. Unreasonable cost (27%; 11 respondents) is the next most mentioned with slightly fewer mentioning poor communication skills (23%; 9 respondents)[13].



When asked what they would consider to be a poor quality dental service, participants in the qualitative focus groups spontaneously mentioned many of the points made in the survey. Specifically, in all focus groups participants talked about pricing being a key cause of dissatisfaction with their dental surgery. This concern was largely made up of two parts: concern that they were being overcharged; and concern that they were not being consulted on treatment which involves additional charge.

> ***"I would be furious if they were overcharging me"***
>
> (Participant in Glasgow group, Older)

[13] Please note the small base sizes.

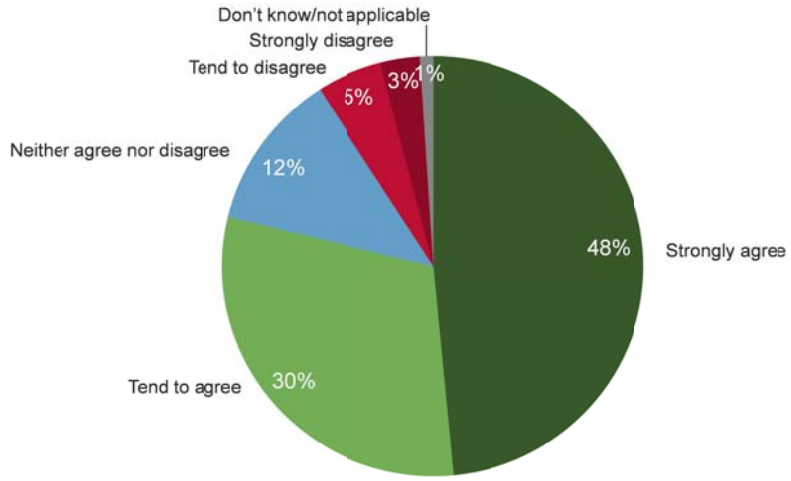
Participants showed frustration at feeling they had little means of discovering if their practice was overcharging and suggested that they did not know what to expect in terms of pricing. This was especially prominent with those who used private dentists as they felt that these dentists could ‘pick and choose’ how much something cost, whereas it was felt that prices were more standardised in the NHS. For many being overcharged or having to pay considerable costs for treatment would be an important indicator of poor care.

3.3 Patient experience of dental professionals’ adherence to General Dental Council Standards

The General Dental Council published new standards in September 2013 that dental professionals should adhere to. These included standards about discussing and agreeing treatment options with patients and displaying information about pricing and regulation of the dental professionals by the GDC. In the quantitative survey, respondents were asked if they recalled these standards being put into practice, the last time they visited the dentist. Over three quarters of people who go to the dentist variously state that their dental professional discussed options for treatment thoroughly with them (78%), gave them enough information about treatment options (78%) and allowed them enough time to make a decision (77%). In each case, approaching half these people *strongly agree* that this had happened during their last visit. Fewer than ten per cent disagree.

Did the dental professional discuss the options for treatment thoroughly with the patient?

Thinking about the last time you visited your dentist or dental care professional, to what extent do you agree or disagree that the following occurred during your visit? The dental professional discussed the options for treatment thoroughly with me.



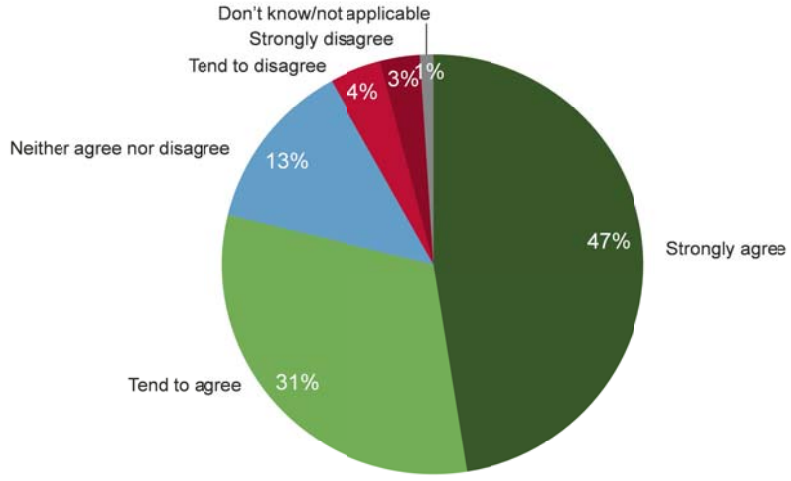
Base: People who go to the dentist (1376)

Source: Ipsos MORI

Ipsos MORI
Social Research Institute

Did the dental professional give the patient enough information about the treatment options?

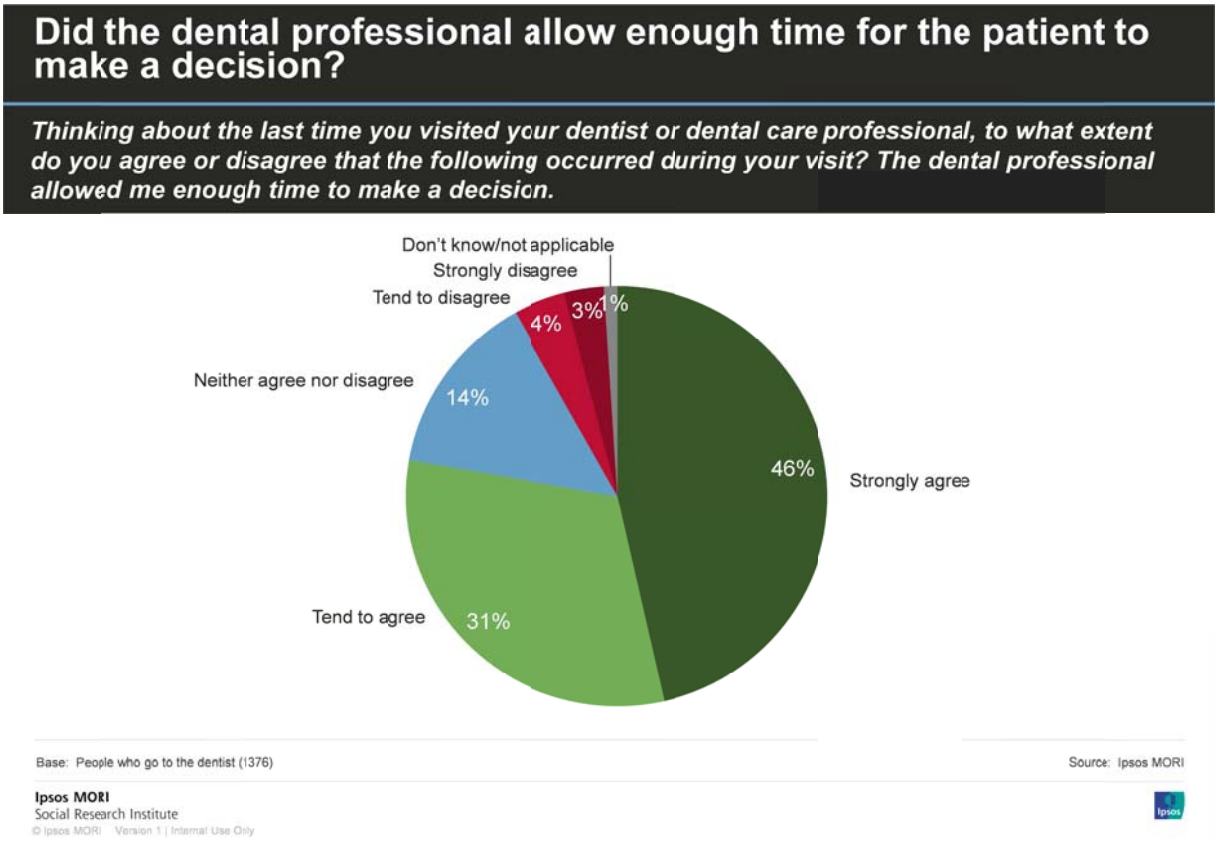
Thinking about the last time you visited your dentist or dental care professional, to what extent do you agree or disagree that the following occurred during your visit? The dental professional gave me enough information about the treatment options.



Base: People who go to the dentist (1376)

Source: Ipsos MORI

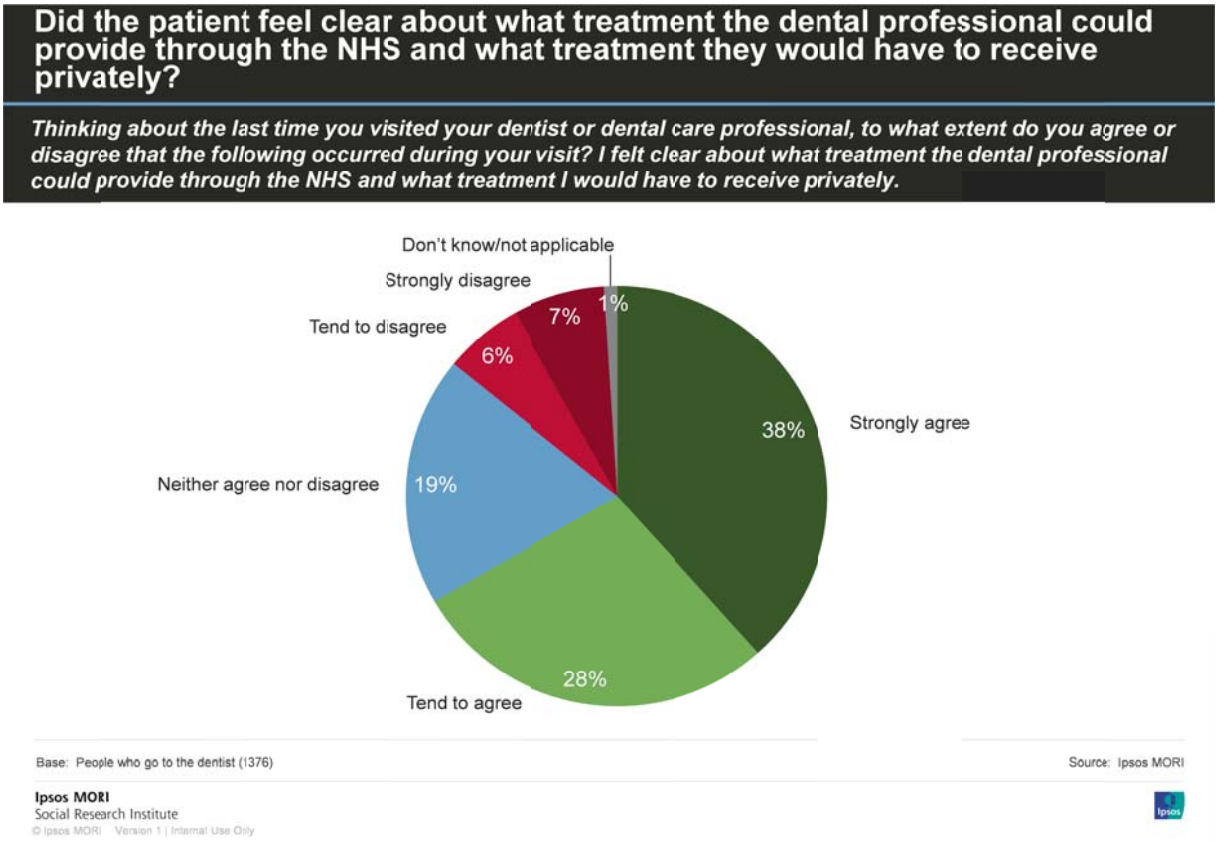
Ipsos MORI
Social Research Institute



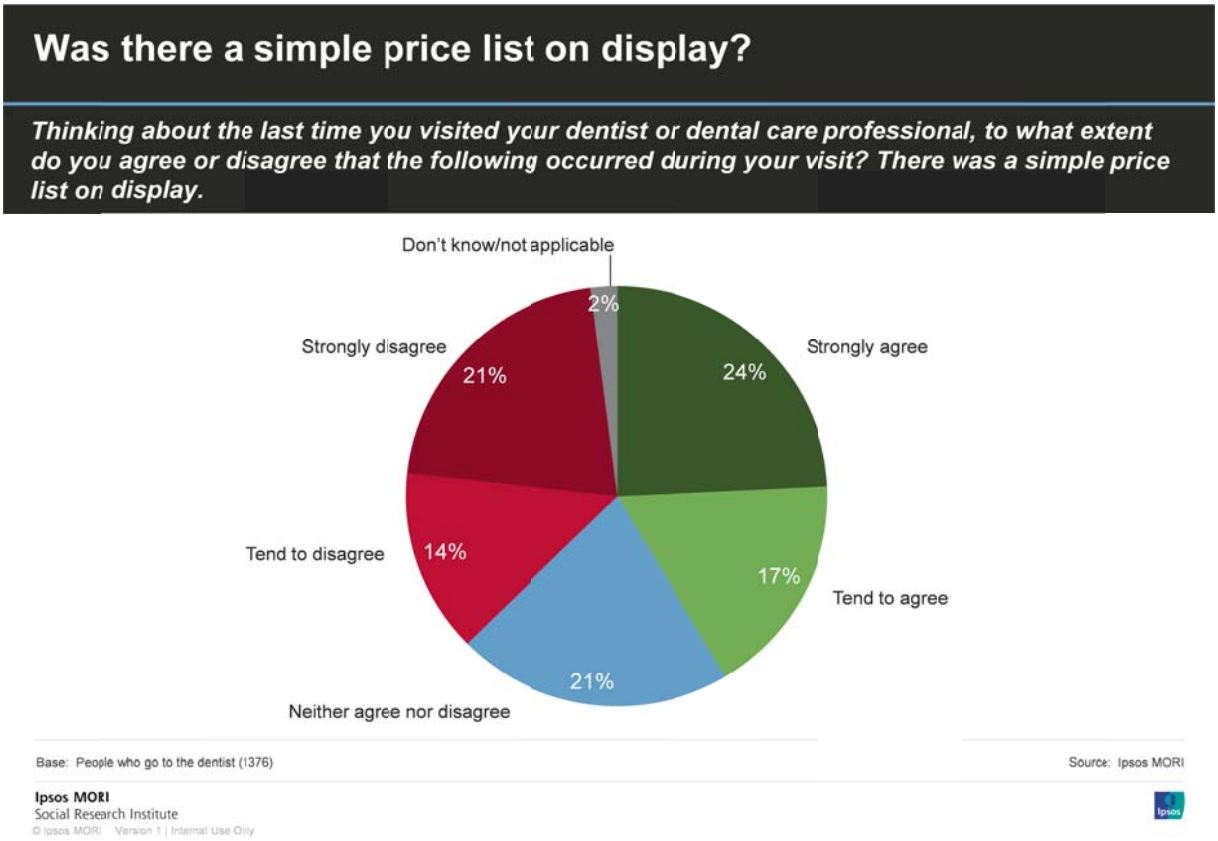
There is little variation of experience across sub groups, although a few are mentioned here:

- Those living in Northern Ireland (16%) and unemployed people (15%) are around twice as likely as others to say their dental professional did *not* discuss treatment options thoroughly with them (8% on average)
- People in social grade E and those of minority ethnic origin are almost twice as likely to say their dental professional did *not* give them enough information about the treatment options available (both 12% compared with 7% average)
- People of minority ethnic origin (15%), in social grade E (13%) and young people aged 15-24 (12%) are similarly around twice as likely as others to say their dental professional did *not* allow them enough time to make a decision (7% on average).

Two thirds of patients overall say they were clear about what treatment the dental professional could provide through the NHS and what treatment would have to be received privately (66%). However, amongst those who receive a mix of NHS and private treatment three quarters (75%) say they received a clear explanation on their last visit.

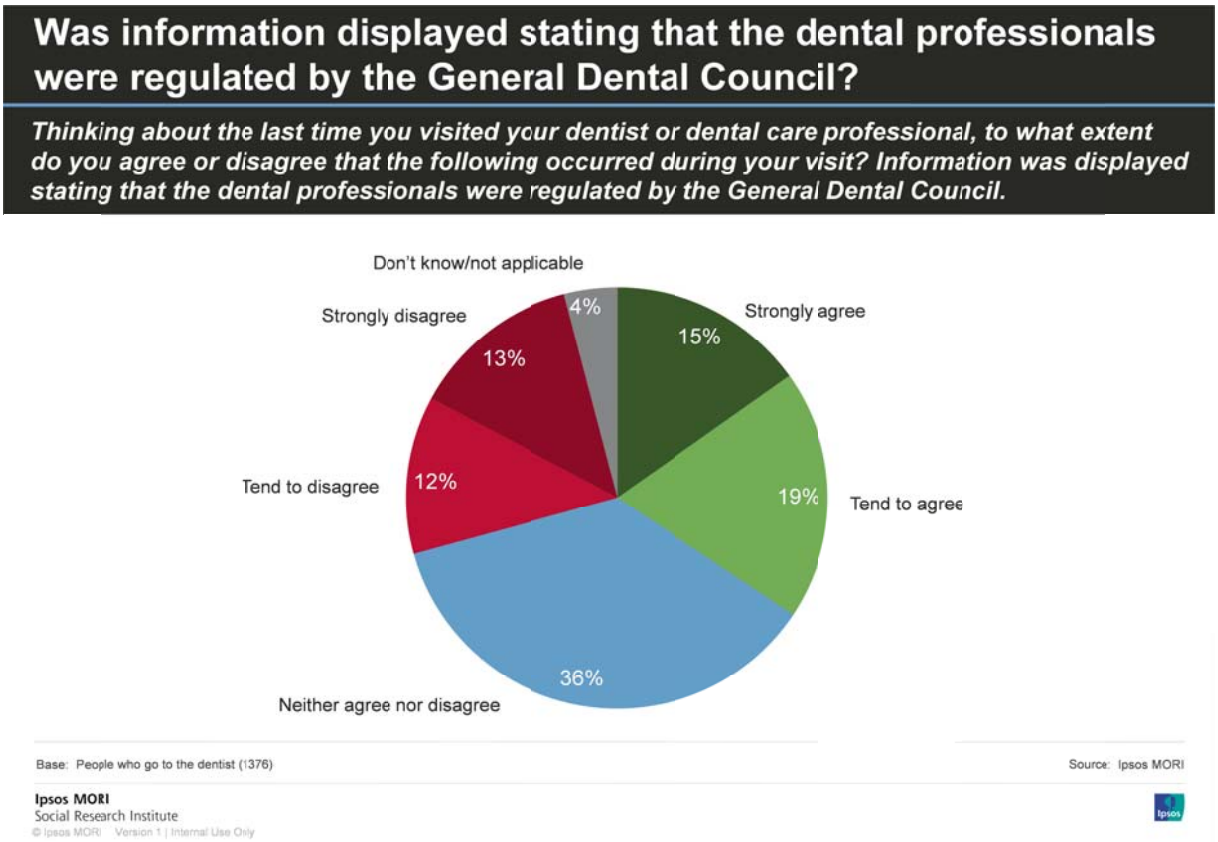


Patients' experience is less encouraging in respect of the display of pricing. Just two in five (41%) say there was a simple price list on display on their last visit, with 23% not sure whether there was or not. One in three (35%) say there was not. However, it should be acknowledged that the requirement to display pricing only came into force in September 2013 and copies of the new standards were only sent to dentists in the autumn. As such, it may be too early to see the impact of this.



There appears to be a slight national bias in terms of good practice in displaying pricing information (or perceptions of it). In Northern Ireland (64%), Scotland (49%) and Wales (47%), patients are significantly less likely to say that there was a simple price list on display. In the Midlands, an above average proportion (49%) remember seeing such a price list.

Only one in three (34%) patients say that information stating that the dental professionals were regulated by the GDC was displayed. The largest proportion (36%) is unsure, while a quarter (25%) say they had not seen this information. Based on patient responses, it appears that displaying information concerning regulation by the GDC may be more prevalent in NHS settings than private practice (38% vs. 30% respectively).



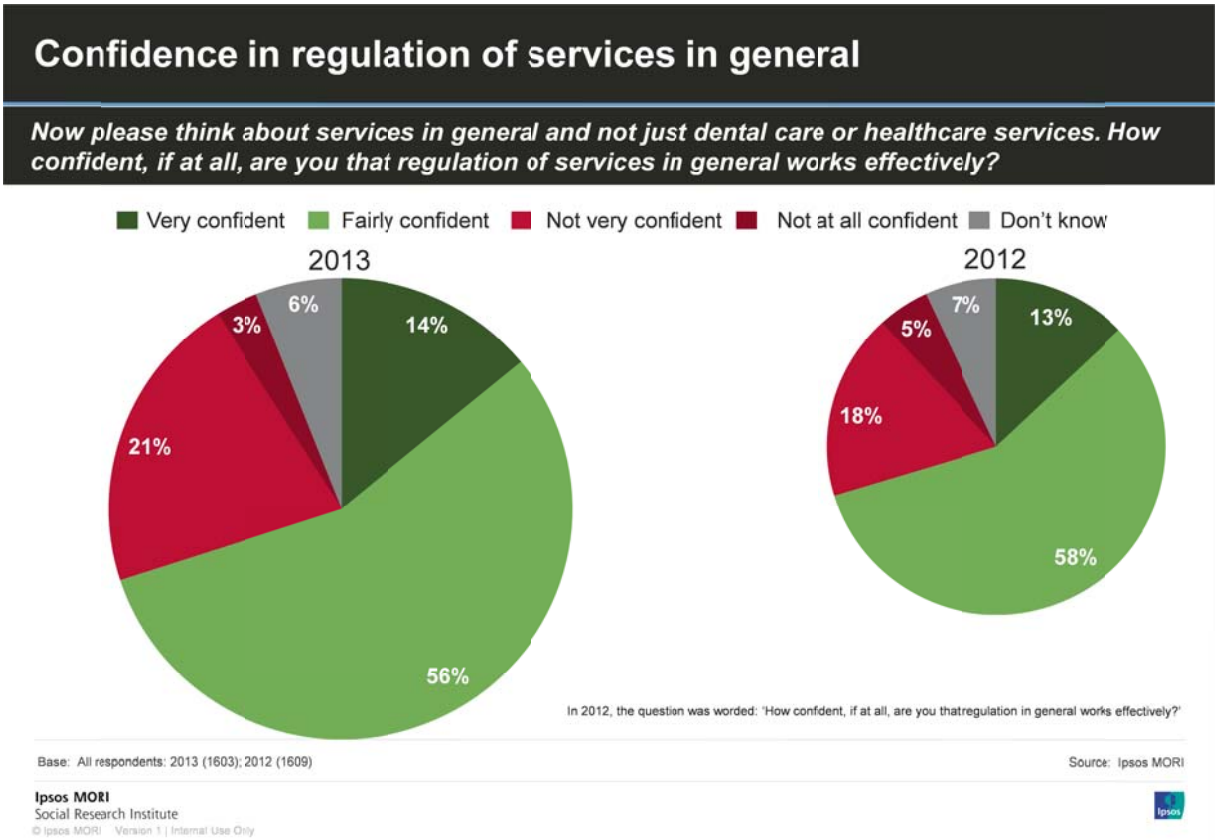
4. Attitudes to regulation

This chapter explores attitudes to regulation, comparing views on regulation in general with those relating to the regulation of healthcare and the work of the GDC.

4.1 Confidence in wider regulation

Regulation in general

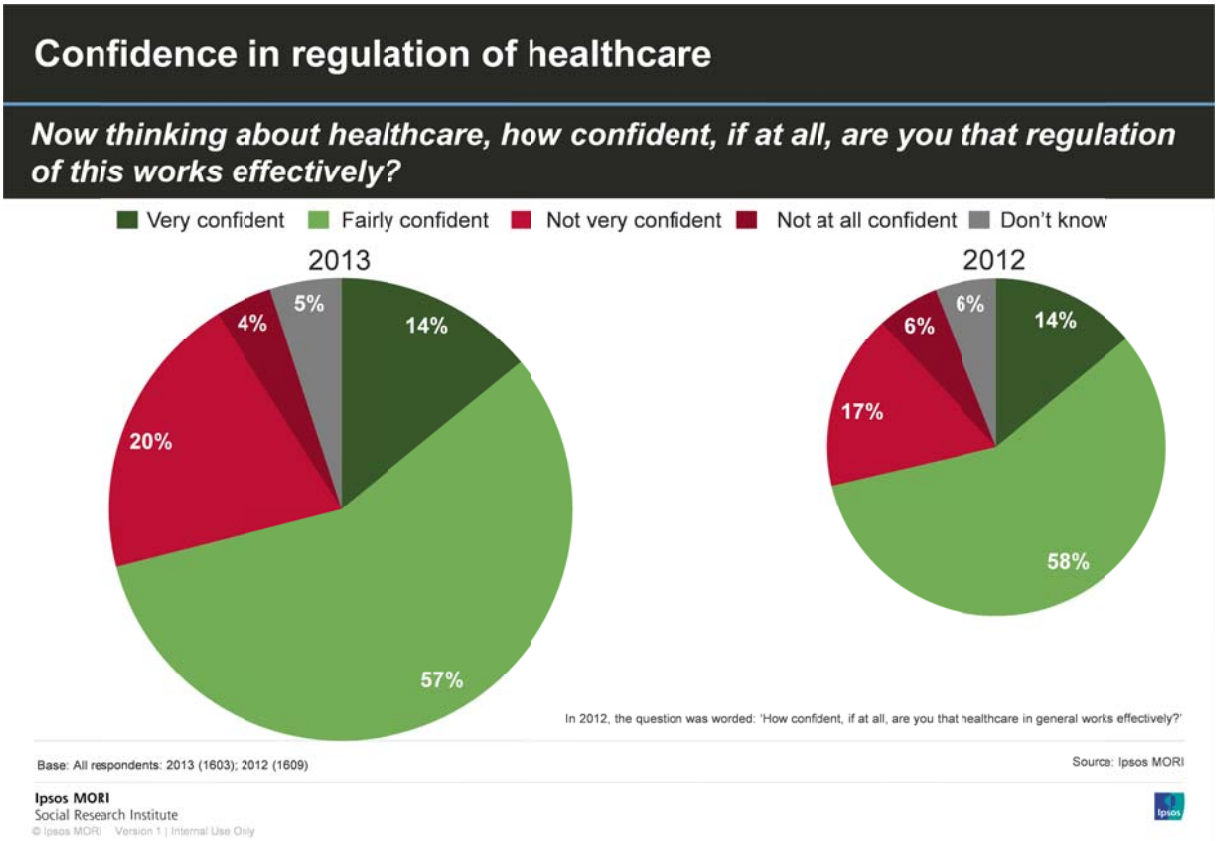
Confidence in regulation in general is high, with the majority of people believing that it is working effectively. Seven in ten (70%) are confident that it works effectively, though only a relatively small proportion (14%) are *very* confident. These findings are very much in line with the findings in 2012. As then, it seems likely that expressed confidence is high even in the absence of detailed knowledge or experience of regulation, perhaps because of a lack of any evidence to the contrary.



Views on regulation in general are relatively consistent across different demographic groups. Confidence in regulation does differ with ethnicity, however, with those from a white background tending to be more confident than those from other backgrounds (71% vs. 64%).

Healthcare regulation

Confidence in the regulation of healthcare specifically is also high (71%) although few are *very* confident (14%). These findings are very much in line with the findings in 2012 and the pattern of responses is almost identical to that just seen in relation to regulation in general. It is likely that the same issues apply, in that people simply have a certain level of faith that the system works if they do not hear of instances where it does not.



Contrary to the findings in 2012, views on healthcare regulation now appear to be quite consistent across the population. While previously, significant differences of opinion were apparent by age, gender, social class and ethnicity, in 2013 the only notable findings are that people aged 65+ are more likely to say they are *very* confident (20% of 65+ year olds compared to 14% on average) and a high proportion of those aged 55-64 tend to be *not* confident (32% compared to 24% on average).

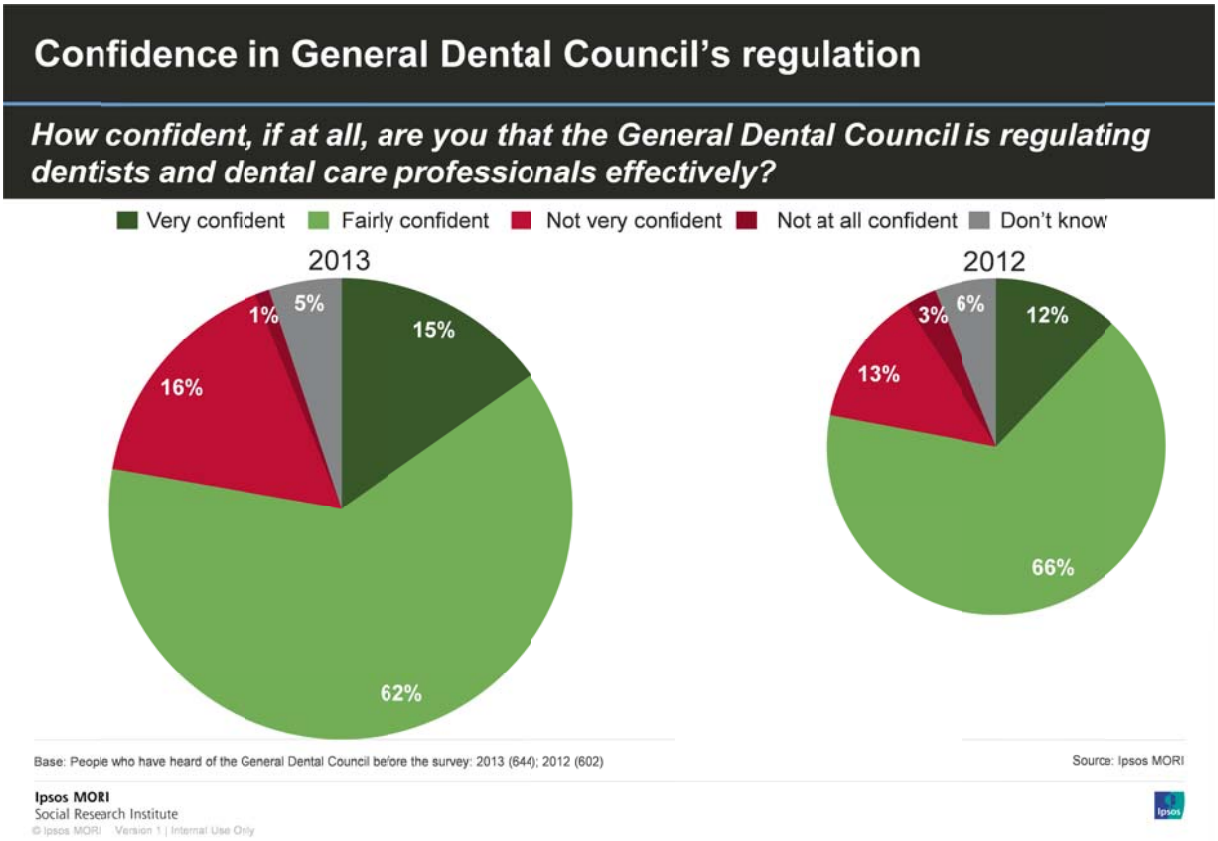
There are also national differences, with a high proportion of those resident in Northern Ireland and Scotland saying they are *very* confident (37% and 21% respectively) about regulation of healthcare. In terms of overall confidence Northern Ireland and London perform best (82% and 78% respectively against an average of 71%), with London residents more likely to say they are *fairly* confident than others (67% compared to 57% on average). In Wales one in three people is *not* confident (33% compared to 24% on average).

4.2 Confidence in dental regulation

Regulation of dental professionals by the GDC

Overall, confidence in the GDC is higher than confidence in regulation in general or healthcare regulation. Almost eight in ten people (77%) are confident that the GDC is regulating dentists and dental care professionals (DCPs) effectively. This question was only asked of those who were aware of the GDC, and so the higher levels of confidence are likely to reflect this greater level of knowledge.

The overall proportion of those expressing confidence in the GDC is similar to the previous two years (77% in 2013, 78% in 2012 and 79% in 2011), although the proportion of those who say they are *very* confident remains lower than it was in 2011 (15% 2013, 12% 2012, 20% 2011). The preceding questions, which were absent in 2011, draw respondents' attention to regulation in general may have affected how people answered this question. Therefore this result should be treated with caution.



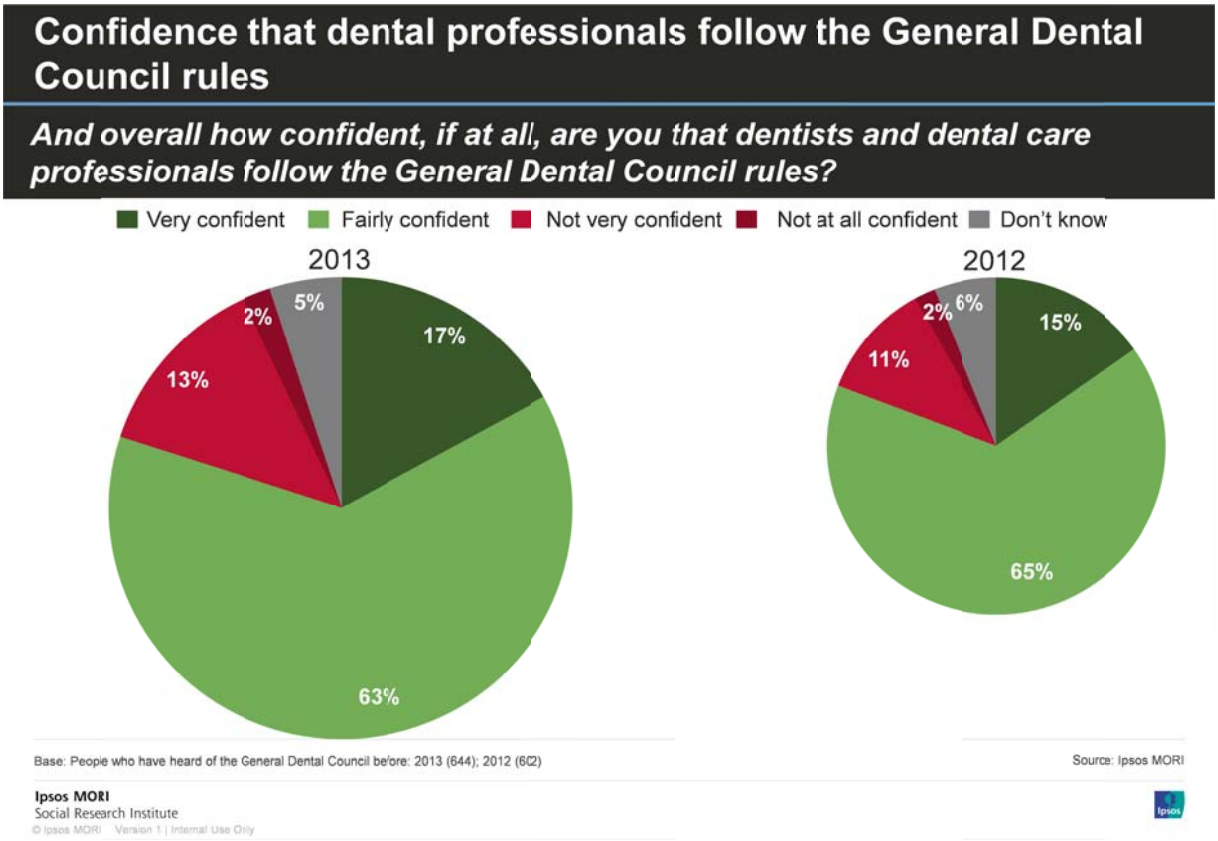
There are few differences by age, gender and social grade, but differences by ethnicity are notable. While three quarters of those from a white background are confident in the GDC's effectiveness, just two thirds of those from an ethnic minority are (78% vs. 64% respectively).

Furthermore, minority ethnic people are twice as likely to say they are *not* confident (35% vs. 16% respectively).

Usage of dental services is also important; those who have visited their dental practice in the last year are more likely to be confident in the GDC's effectiveness than those who have not (81% vs. 67%).

Confidence that dental professionals are following GDC rules

Those with knowledge of the GDC are also likely to believe that professionals are following the rules. As in 2012, eight in ten (80%) people are confident that dentists and DCPs follow the GDC rules, including almost one in five (17%) who are very confident.



Patients who have seen a dentist in the last 12 months are more likely to say they are confident (84% vs. 72% overall), as are those who visit the dentist at least once a year (85% are confident compared with 25% who visit less often). This again illustrates the association between frequency of contact with dental professionals and confidence. Women are more confident than men (85% vs. 76%), though this perhaps reflects the fact that women are also more likely to visit the dentist regularly. Differences by ethnicity are not significant here.

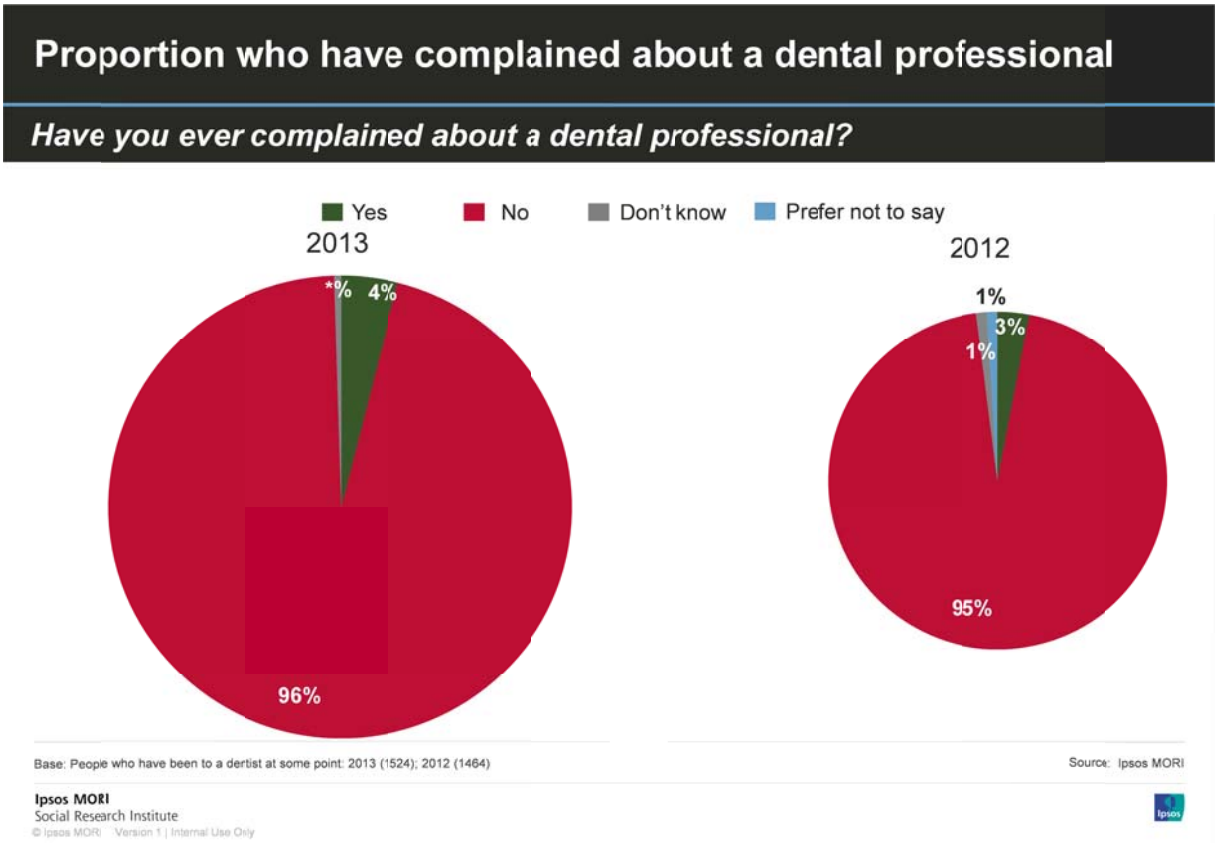
5. The complaints process

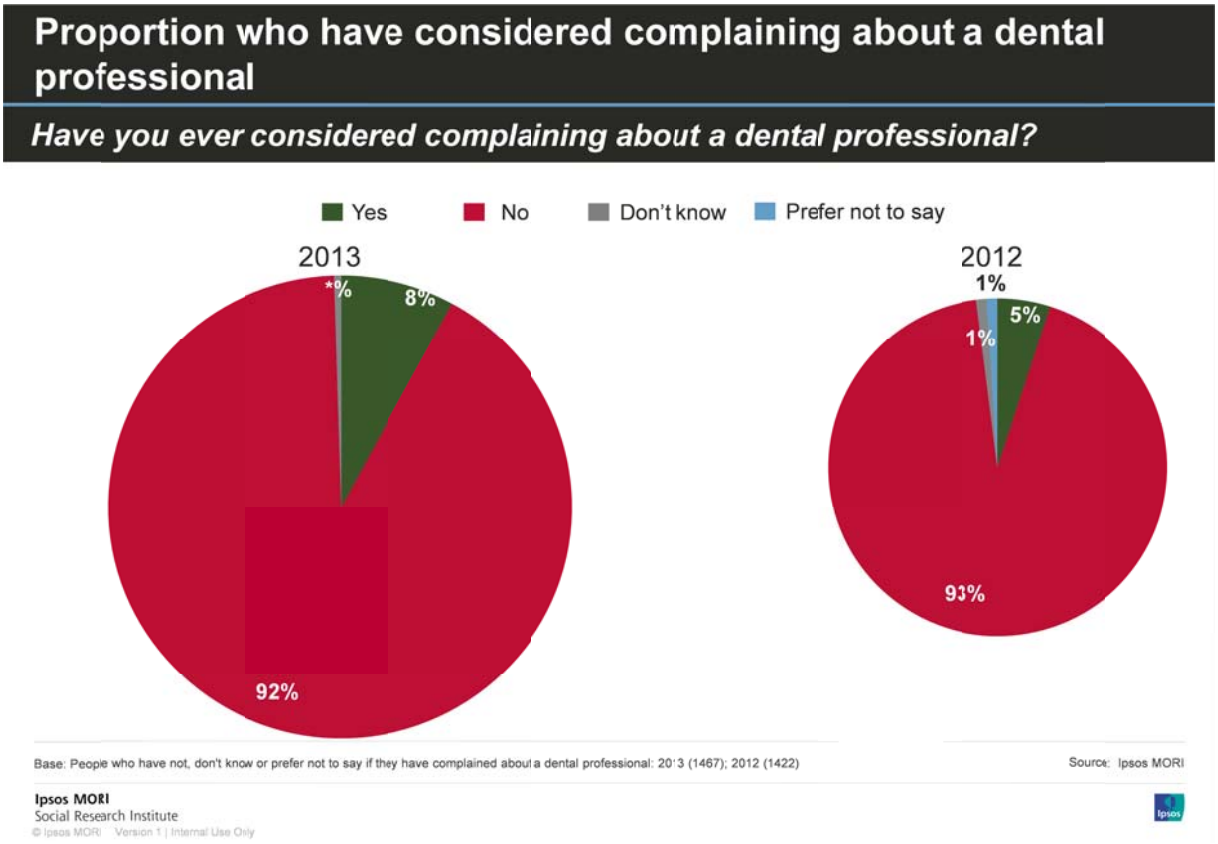
The survey included a series of questions about patient complaints. Generally these focused on gathering broader information on motivations and barriers to complaining, rather than looking at the GDC's Dental Complaints Service or Fitness to Practise processes.

5.1 Making a complaint

People who have complained or considered complaining

Few people say they have complained (4%) or have considered making a formal complaint about a dental professional (8%). There is no notable change here compared to the previous surveys.



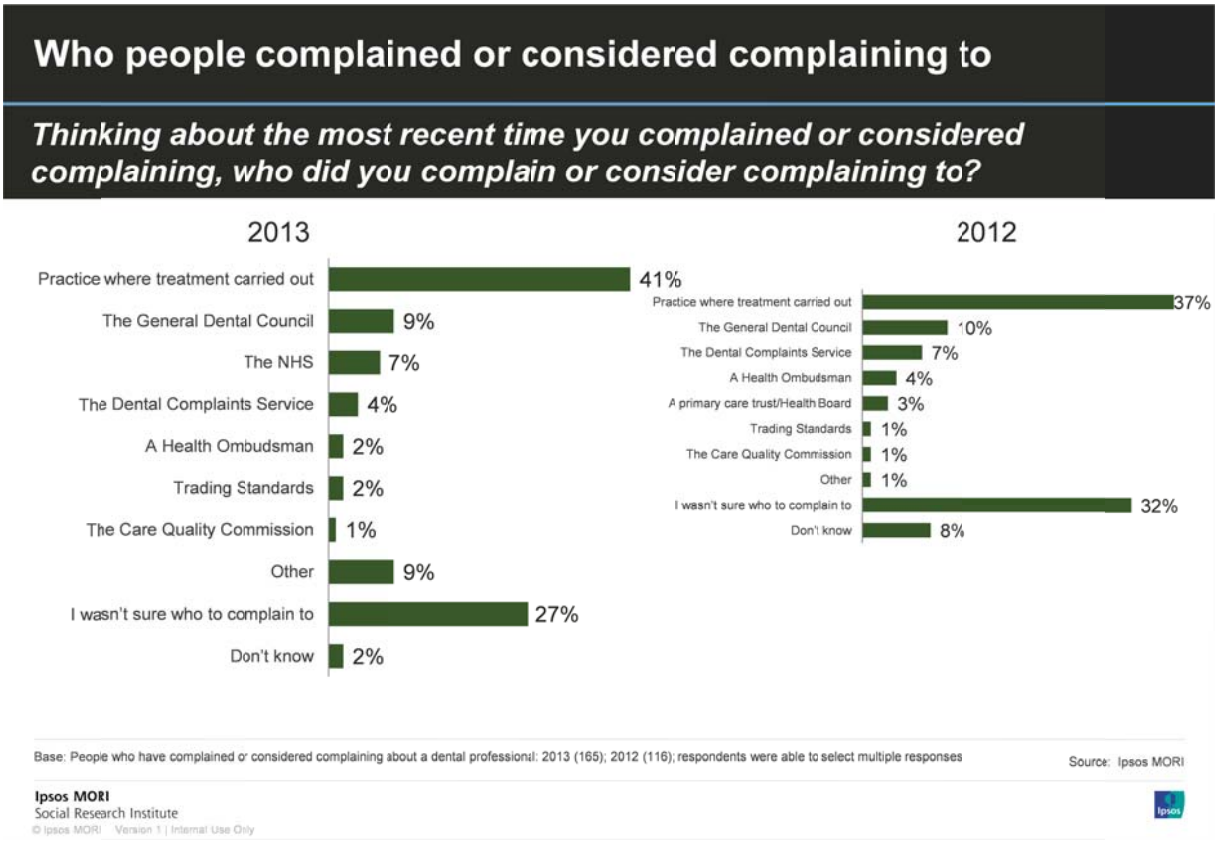


There is little significant difference between subgroups, although those most likely to have considered complaining whilst not actually doing so are in social grade A (17% or nine people).

Who people complain to

When people do complain they prefer to speak directly to the practice where they received treatment. Two in five (41%) people who complained or considered complaining approached their dental practice (or considered doing so) while nine per cent thought of the GDC.

Perhaps more importantly for the GDC, over one quarter (27%) said they were not sure who to complain to. Consequently, while it could be assumed that the vast majority of people are happy with their dental care services given the small numbers who do or may wish to complain, it remains a possibility that a greater proportion is dissatisfied but doesn't even consider seeking redress because they do not know how to speak out effectively.



These findings are in line with the previous survey in 2012; apparent differences are not significant due to the small base sizes involved. Similarly, sub group differences cannot be considered given the small number of people in total saying they have or would like to complain.

Understanding the decision-making process

The focus groups explored the area of complaints further, with a particular aim of understanding the decision-making process for patients. A number of triggers emerged, including repeat experiences and the severity of the incident. However, participants also

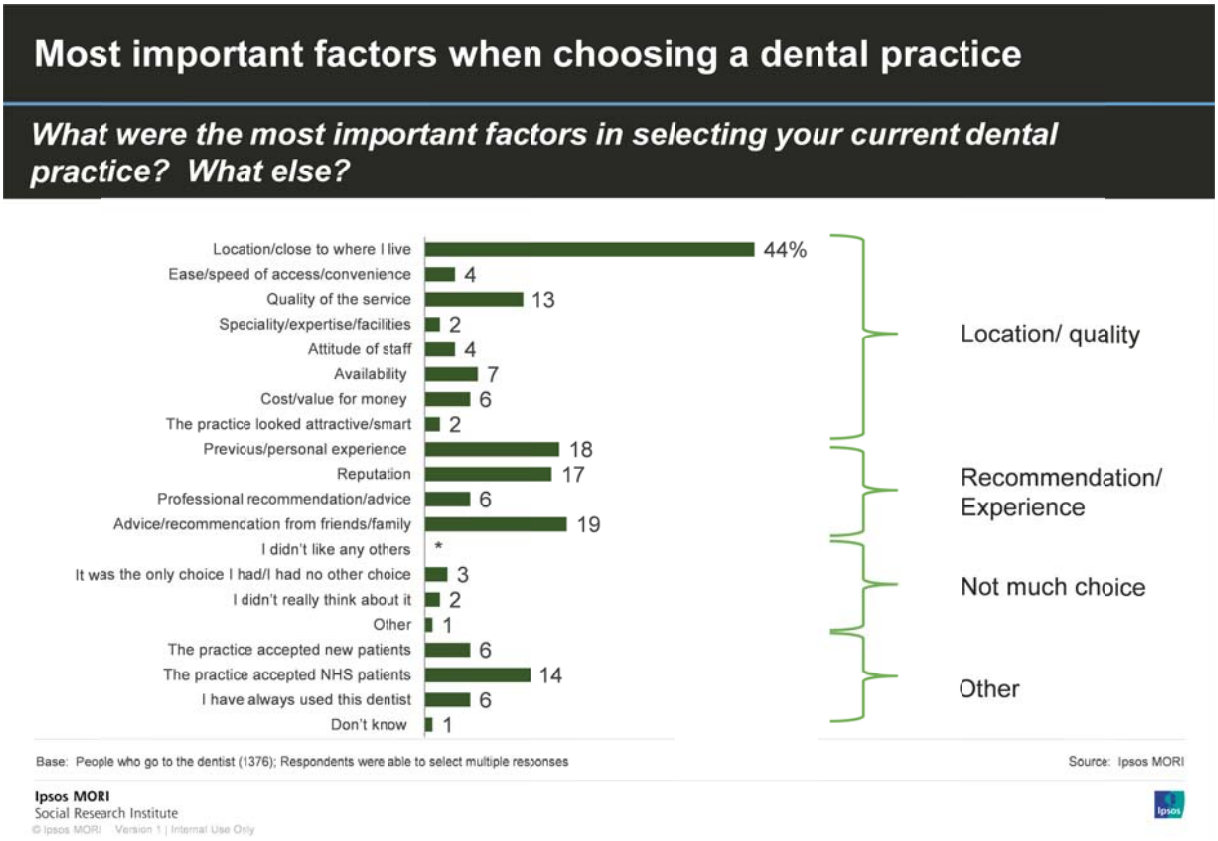
talked about a number of barriers, largely focusing on a lack of knowledge about what standards they could and should expect. These points are discussed in more detail in Chapter 9.

6. Choosing a dental practice

This chapter explores the way in which patients choose a dental practice, looking at the range of factors influencing their choice and their decision-making process. It specifically provides information on the extent to which patients check the history of dental professionals before making their choice. Finally it covers potential attitudes towards the introduction of a star rating system.

6.1 Factors driving choice

The location of the practice is by far the most important factor when choosing a practice (44%). In addition, patients rely on the recommendation of friends and family (19%) or personal experience (18%). Professional recommendation or advice appears far less important (6%), but 17% refer to the reputation of the practice and just over one in ten mentions the quality of the service (13%).



The findings are similar to those from a survey about choice Ipsos MORI conducted for the Cabinet Office[14], where people were asked a similar question about registering a child at a

[14] Choice Review Survey Summary Report, Ipsos MORI, 2012 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/80072/Choice_review_survey_IpsosMORI.pdf

school; registering with a GP surgery; being a patient at a hospital (excluding A&E), or being a user of or carer of someone that uses social care services. By far, the main consideration when selecting a service was location (55%) or ease of access (10%). Quality and reputation - both mentioned by 15% - rank joint second as key considerations but behind location by some way.

As might be expected, different population groups appear to be motivated in subtly different ways when choosing a dental practice.

- Women are more likely to take into consideration recommendation/ experience (55%), cost/value for money (8%) and attitude of staff (6%) compared to men.
- For people of a minority ethnic background, quality of service (19%) and cost/value considerations (11%) are more significant than for white patients.
- There are no significant differences by social grade and little of note between countries.

The qualitative research confirmed and expanded on the results to the survey. Participants talked about a combination of factors as being important, particularly location and the recommendation of friends and family. While not volunteered by participants, the fact that the practice was accepting new (NHS) patients was critical. Thus, these factors tended to work in conjunction with each other so that a patient would usually ask friends and family for a recommendation for a local practice, with an assumption that the practice was accepting new (NHS) patients. If it transpired that this was not the case, then the patient would have to select an alternative practice, which perhaps was a little further away or not quite as highly recommended.

When asking for a recommendation, patients did not seem to be specific in their needs or their request. They would simply ask their friends and family if they were happy with their own dentist, with no further clarification as to what they were personally looking for. If prompted they expected a number of factors to influence whether a dental practice would be recommended, including the quality of care provided, the manner and professionalism of the dentist, the cleanliness of the practice and the cost of treatment. Specific factors are discussed below:

Location:

Participants believed that most people traditionally chose to go to their nearest practice as this would be most convenient to them. Some explained that they considered issues such as

transport and parking when deciding which practice would be most convenient. Many participants had high expectations believing that any dentists or dental health professionals would be able to offer them a good service as they would have received the necessary training to do this. As such, if all practices offered a similar high standard of service, then location and access were crucial deciding factors.

> ***"There's a few, but then distance becomes a bit of a problem, you see, and then parking... there's not an awful lot of parking in the area, so, and having to travel there by car is difficult, to be quite honest."***
>
> (Male/ Age 45 plus/ Social Grade A)

While most currently considered location and convenience to be the most important factors when choosing a dentist, some participants (particularly those who had been using their dentist for some time) suggested they would have a more consumerist mind-set if they needed a new dentist in the future and would be more willing to shop around than they might have been in the past. This may relate to the increased focus on choice in health services in recent years, and the relative ease of reviewing products and services online now.

Personal recommendation:

The second most important criterion for participants was the personal recommendation of a practice from friends and family members living in the area. Participants particularly appreciated personal recommendations as it allowed them to hear from somebody they trusted and who understood their likely concerns and needs. Some explained that they would often ask their friends and family about the soft skills exhibited by the dental health professionals working in the practice. They explained that they preferred practitioners who understood them, appeared competent and professional and were not judgemental (particularly if patients had not been looking after their teeth in the past). One younger participant explained that she chose her practice on the advice of her parents, while several parents explained that their (young) adult children had continued to use the same practice after leaving home.

> ***"It was more convenient. It's local, through mother's recommendation because she goes there on a regular basis"***
>
> (Male/ Age 45 plus/ Social Grade C1)

Other factors:

Other factors were less likely to be raised, and often only mentioned after prompting. Some explained that the look of the building had an impact on their decision about whether to use a practice and that they would not have joined a practice which looked dirty or unprofessional.

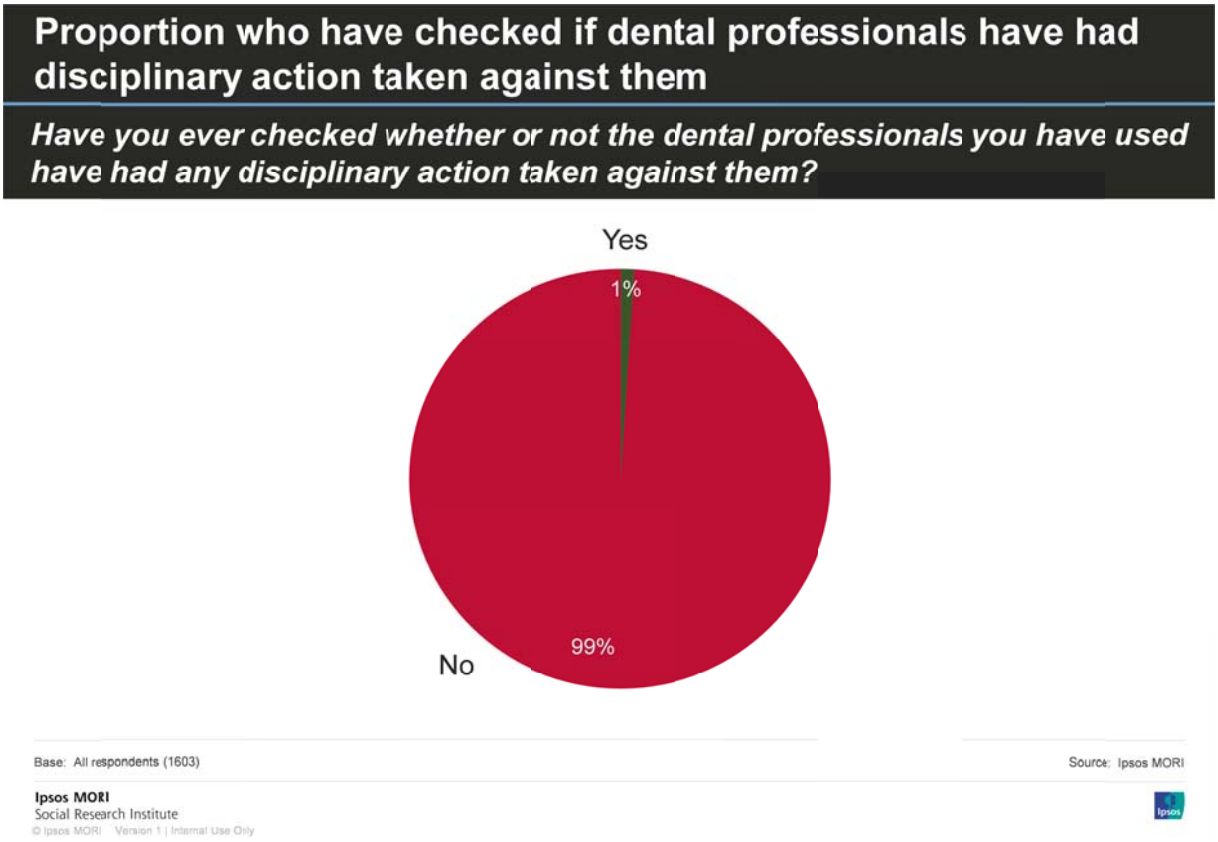
The **quality, expertise, and soft skills** of the dental health professionals was only considered when participants had a personal recommendation as participants did not feel equipped to make a judgement call on these factors. Participants explained that they would leave a practice and not recommend it to others if they felt the dental health professionals were offering a poor service or did not have the soft skills necessary to make them feel at ease and confident about the treatment that they were receiving. Patients who were more nervous about visiting a dentist were most likely to be concerned about the quality of the service they received.

> ***"Well if people find the dentist to be rude or arrogant in any way, or belittling….would put me off"***
>
> (Female/ Age under 45/ Social Grade E)

Participants' perceptions of their own financial situation had a major impact on the degree to which they were concerned about the cost of any treatment that they received. This may explain why younger people aged 25-34 were more likely consider cost and value than other groups. However, whether or not there are standard costs for treatments was not clear to most people and so this tended not to be one of the main factors influencing their choice of practice.

6.2 Checking for history of disciplinary action

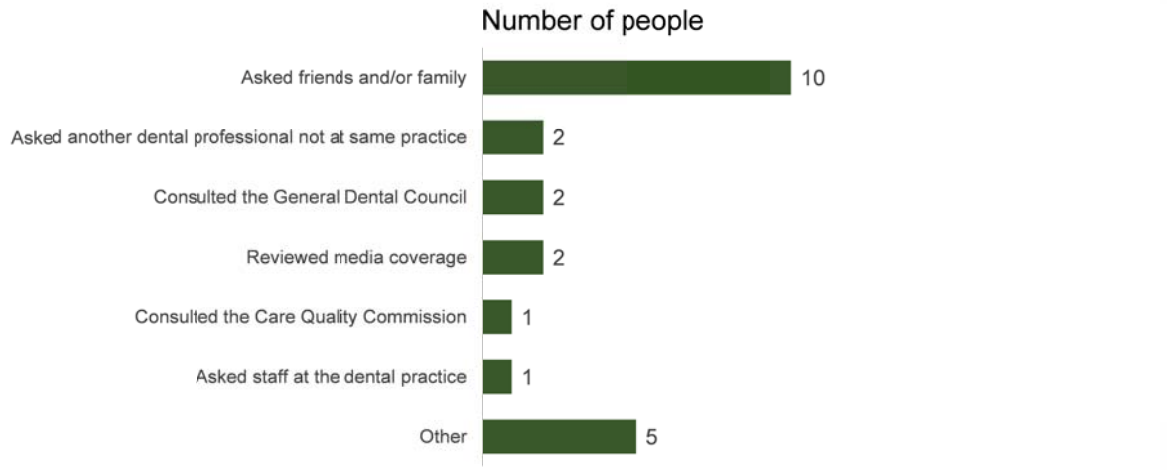
Just one per cent of people says they have checked whether or not the dental professionals they use have had any disciplinary action taken against them.



Among the twenty two people who had taken such action, around half (10 people) had asked their friends and/or family. Just two people had consulted the GDC, the same number as had asked another dental professional not at the same practice, or had reviewed media coverage.

How people checked if dental professionals have had disciplinary action taken against them

How did you check this?

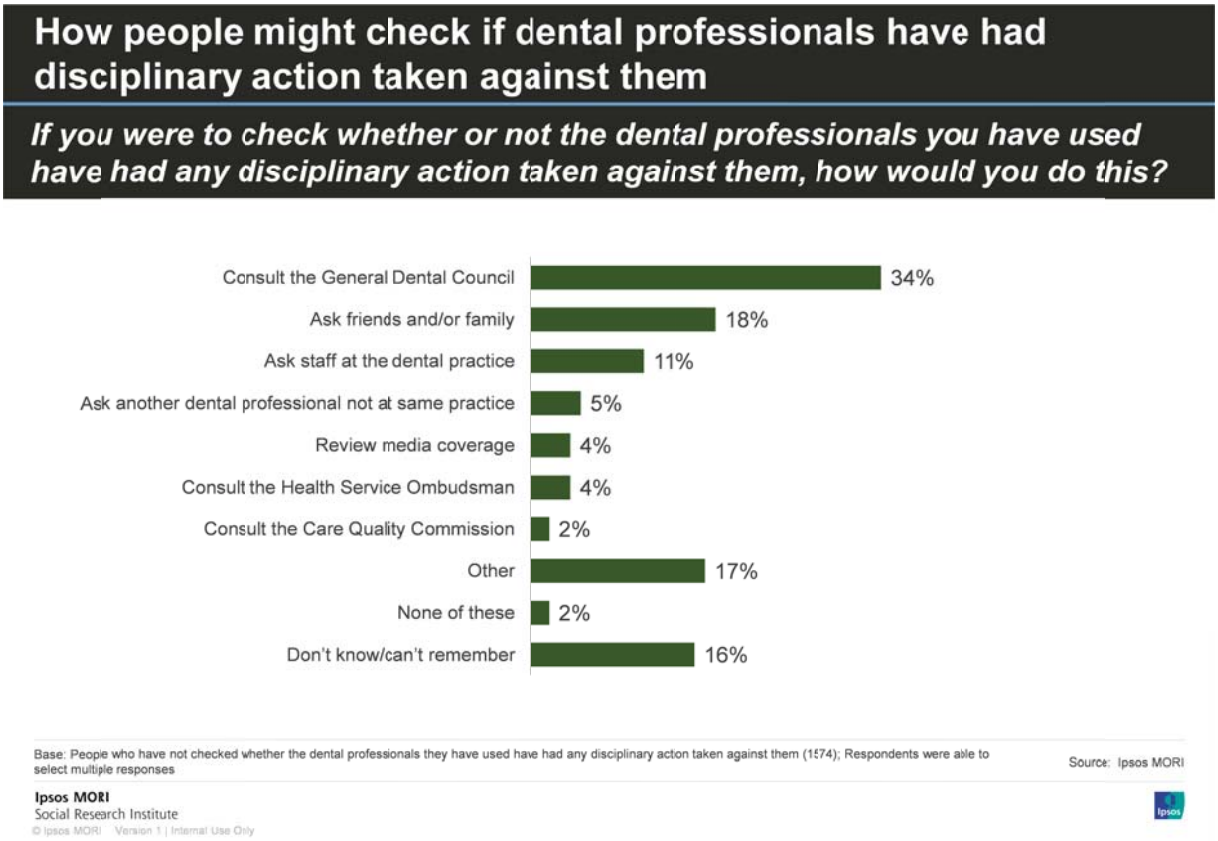


Base: People who have checked whether the dental professionals they have used have had any disciplinary action taken against them (22 weighted; 29 unweighted); respondents were able to select multiple responses

Source: Ipsos MORI

Ipsos MORI
Social Research Institute

For those that have not checked, the GDC was more prominent as a potential source. Here, one in three (34%) think they would consult the GDC[15], while only half as many (18%) say they would ask friends and/or family. One in ten (11%) said they would ask staff at the same practice and one in twenty (5%) would ask a professional at another practice.



The depth interviews suggest that people have little interest in checking whether their dentist has a history of disciplinary action, and it had simply not occurred to them that they would want or need to do so. They explained that the idea of searching for this information was not 'top of mind' as they assumed that any dentists who had been disciplined for a serious offence would have been struck off, and that any dentist who had been disciplined for a minor offence and not struck off would be capable of doing a good job.

> ***"They wouldn't be practising if they weren't qualified"***
>
> (Male/ Age 45 plus/ Social Grade A)

[15] It should be noted that respondents would have been more likely to mention the GDC by this point in the interview.

Discussion of other professions was useful in prompting more detailed consideration of this issue and revealed a number of factors that would prompt individuals to check a professional's history. Contrasting these with the dental profession was particularly revealing. For example, participants felt that they would be likely to check on child minders as the individual would be responsible for their child and they would not be overseen by a parent. In contrast they noted that they would be able to stay with their child at the dental practice.

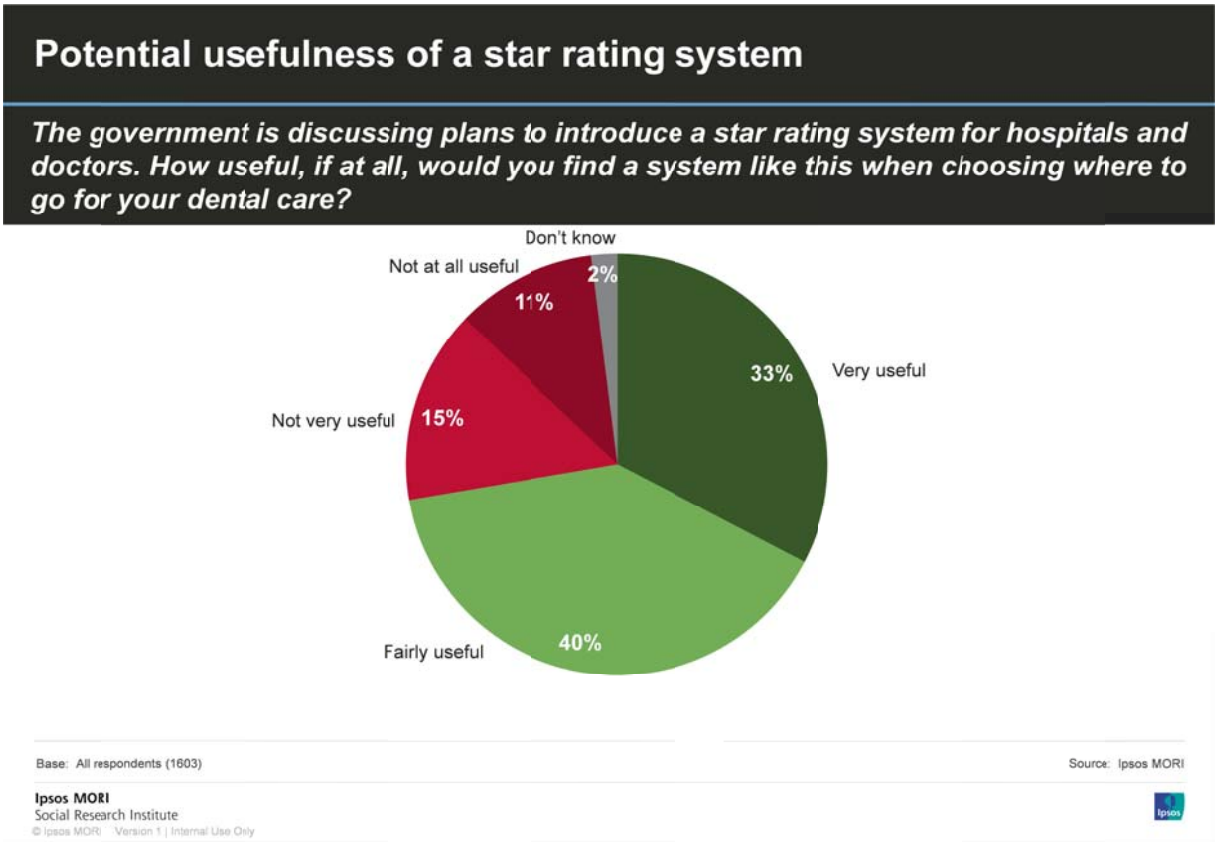
There was also some desire to check on builders, plumbers and car mechanics as there was less trust in these professions compared to dentists. Again, participants assumed that dentists would simply not be allowed to practise if they had done something significantly wrong.

As with dentists, there was little desire to check on GPs or opticians. Most explained that they trusted these professionals in the same way as they trusted dentists. The brand associations were also important for GPs and opticians, with GPs associated with the NHS and opticians often associated with popular brands such as Boots. However, some suggested that they would be even less likely to check a GP's history because they were confident that they could find another surgery (or GP within the same surgery) in the future if they were not happy with the service they had been provided with. They contrasted this with dentists where they felt finding a new practice may be more difficult. Therefore, they suggested that it was perhaps more important to select the 'right' dentist in the first place. When prompted, some participants felt they *might* check whether their dentist had faced disciplinary action in certain situations; for example, if something had gone wrong in their treatment; they had heard something negative from a friend or in the media and wished to investigate; or when choosing a new dentist in the future (now that they had thought about it more). Therefore, they believed that this information should be available to those who wished to search for it, and they appreciated its potential value. Most participants felt that the information should be available on the Internet, although they noted that many people do not have internet access so this would not be accessible for all.

6.3 Support for a star rating system

The government is discussing plans to introduce a star rating system for hospitals and doctors (for example, rating hospitals from one to five stars where five stars indicates 'excellent' performance and one star 'very poor' performance).

Almost three quarters (72%) of people think that this would be a useful system when choosing where to go for dental care, including a third (33%) who think this would be *very* useful. A quarter (26%) does not see this as particularly useful, however, including 11% who say *not at all.*



The strength of support for a rating system differs among different age groups. Those aged 15-34 are most likely to be supportive, while those aged 45 or over are less so (79% vs. 67%).

Participants in both aspects of the qualitative research expressed some support for rating the star rating of dental practices, however this was not unanimous or overwhelming. It was a concept that required detailed explanation and there were a variety of views about how the system could most effectively be implemented.

Those who said they would use a star rating system to choose a dentist in the future tended to be more consumerist in their approach to choosing a new dentist. Indeed, in a number of

the consumer and mixed focus groups, a star rating system was mentioned spontaneously. They were more likely to be happy to 'shop around' for a new dentist rather than automatically opt for one located closest to their home. One participant who was nervous about visiting dentists believed that such a rating system would help her feel more confident about going to the dentist as she would be able to avoid dentists who had poor ratings.

> ***"If a dentist only had a couple of stars then I wouldn't be so tempted to go than if it had a five star rating …it would be important to me…if they had four or five stars I would definitely look into going there."***
>
> (Female/ Age 45 plus/ Social Grade C2)

Often people said they would use the rating system in collaboration with other considerations, (such as the location of the dental practice, or recommendations from family and friends) and not rely on the rating alone.

Participants' suggestions for the design of the rating system were based on their experience of using similar systems. For example, a woman who had used the rating system on Amazon suggested that something similar could be used, while a man who was more familiar with the energy rating system gave this as an example of something he would like to use. Several equated it to Trip Advisor.

> ***"We should really be encouraged to give feedback on everything that we do… On Amazon you give feedback on the items that you got"***
>
> (Male/ Age 45 plus/ Social Grade C1)

There were mixed views about whether or not it would be better for a rating system to use stars or to use words (for example the Ofsted rating system which rates schools as 'outstanding', 'good', 'requires improvement' or 'inadequate'). Some felt the star rating approach would be too simple, whereas others thought the Ofsted style approach might not mean much to the general public. A combination of the two might address this, for example having a star based approach, with an accompanying summary sentence or paragraph explaining what each number of stars represents. This should be short and succinct and in accessible language.

When asked what should feed into the rating system, most initially thought it should be based primarily on the feedback of patients. However, when prompted further, some believed that an independent body should carry out official inspections of practices and combine this with patient feedback to determine the ratings.

A small number of participants explained that they would not use any sort of rating system to help them choose a dentist. Many were so satisfied with their own dentist that they did not think they could personally benefit from a rating system. Others were concerned about the potential risks of such an approach; this was very pronounced in the focus groups. They were worried that the system might be inaccurate, or might not offer sufficient granularity for patients to make a decision about where they wished to go. One participant was concerned that a system based on patients' ratings could be abused by a vindictive or overly fussy individual marking down services that they had used.

> ***"How would you transfer these to an objective review of your dentists….Sometimes it can be abused"***
>
> (Male/ Age over 45/ Social Grade A)

Often these views were based on personal experiences of using Trip Advisor and other star rated systems where they suggested that often reviews are shown to be very subjective to individual personal opinion. Some of these people did recognise that a rating system could have benefits though, as they believed in the principle of encouraging transparency as a way of improving services.

Within the focus groups, there was also discussion of a star rating system being produced by those with expert knowledge in the field, with discussion of the potential of the GDC providing this. While there was some support for this as individuals felt it would be less partial, concern was expressed with the ability of those producing the ratings to accurately reflect the views of the patients. Many said that this type of star rating should be based on visits by those producing the ratings. However, there was concern that, as with perceptions of Ofsted, dental professionals would be able to prepare in advance for inspections and so look better than they actually are. As such, for those who felt that a more specialised organisation should produce the star rating, it was felt that mystery shopping would be essential. There was also concern that if a specialised organisation produced the rating then people would only choose those practices rated as 5 star:

> ***"If it was rated by the GDC you would never go to one that wasn't five stars, you wouldn't go to one that was three or four"***
>
> (Participant in Glasgow, younger mixed)

These findings fit with other research on the use of ratings in healthcare settings. For example, the public thought they could be useful as a point of reference, but would not

necessarily be a deciding factor in driving choice. It was also felt that poor ratings could drive underperforming services to strive for improvements. There was some resistance on the basis that all health services should be of the same high standard and they did not always have a choice about where to go for services.

7. Dealing with poor care or wrongdoing

This chapter looks at public perceptions of poor care and wrongdoing by dental professionals and expectations of actions taken to deal with incidents.

7.1 Dealing with poor care or wrongdoing

Perceptions of poor care and wrongdoing

The qualitative interviews revealed that a distinction was drawn between poor care and wrongdoing. Participants assumed that "poor care" suggested a lack of competence. One person suggested that a dentist using dirty tools would be offering poor care, while another gave the example of her having a cracked tooth as a result of another tooth being badly pulled out. Some participants suggested that poor care might not always harm a patient but may increase their *risk* of harm.

> **"*Poor care etc. it just means that the treatment hasn't been [to the right] standard]. For example, if the tools they use are not clean or they haven't been sterilised*"**
>
> (Male/ Age 45 plus/ Social Grade C2)

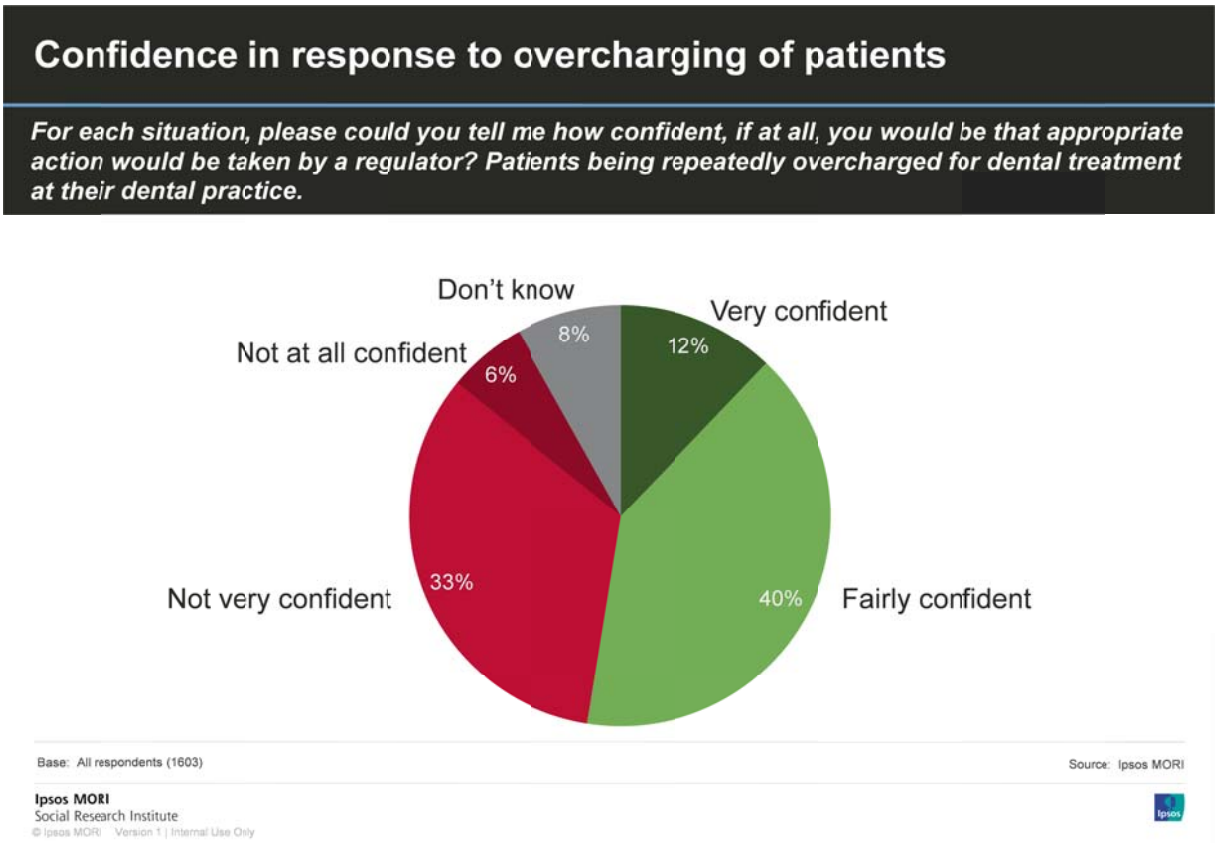
In contrast, "serious wrongdoing" was associated with very poor treatment or with patients receiving significant and certain harm as a result of their treatment. Participants often assumed that this phrase described a major incident that might result in disciplinary action being taken. It is worth noting that this discussion took place after participants had already answered questions on disciplinary actions, something that may have influenced their assumptions.

> **"Serious wrongdoing, well that's just clearly doing something that they shouldn't be, and they should be reprimanded for it."**
>
> (Female/ Age under 45/ Social Grade E)

Those taking part in the quantitative and qualitative interviews were presented with a number of specific examples of poor care or wrongdoing to explore their views further. These are discussed in the remainder of this chapter.

Over-charging

Half (52%) the public is confident that appropriate action would be taken by a regulator to address a situation where patients were being repeatedly overcharged for dental treatment at their dental practice, and just one in eight (12%) is *very* confident. Further, a significant minority (40%) is not confident, including six per cent who say they are 'not at all' confident.



A negative view is most clearly held by those in the highest social grade. Among those in social grade A, two thirds are *not* confident and among social grade B almost half think this (68% and 46% respectively). People living in London are most confident across the regions appropriate action would be taken (63%), while those in the South of England most likely to be not confident (45%).

In line with this, those who receive only private dental treatment are more likely than those who receive only NHS treatment to say that they are not very confident that appropriate action would be taken by a regulator if patients were being repeatedly overcharged by their dental practice (49% to 38% respectively). The depth interviews revealed that some people assume that a dental practice could not really overcharge for a treatment as dental professionals working outside the NHS are allowed to set their own charges. Therefore this would not be defined as wrongdoing. In addition, some argued that patients should be aware

of any charges before any treatment takes place and have the option of moving practice if they were unhappy with the cost.

As noted earlier, in the focus groups, the issue of overcharging was one that concerned the majority of participants. There were concerns that it was not possible to know what a reasonable price for treatments was. Consequently, a number of participants called for the GDC to provide them with information to help them have clarity on what to expect to pay.

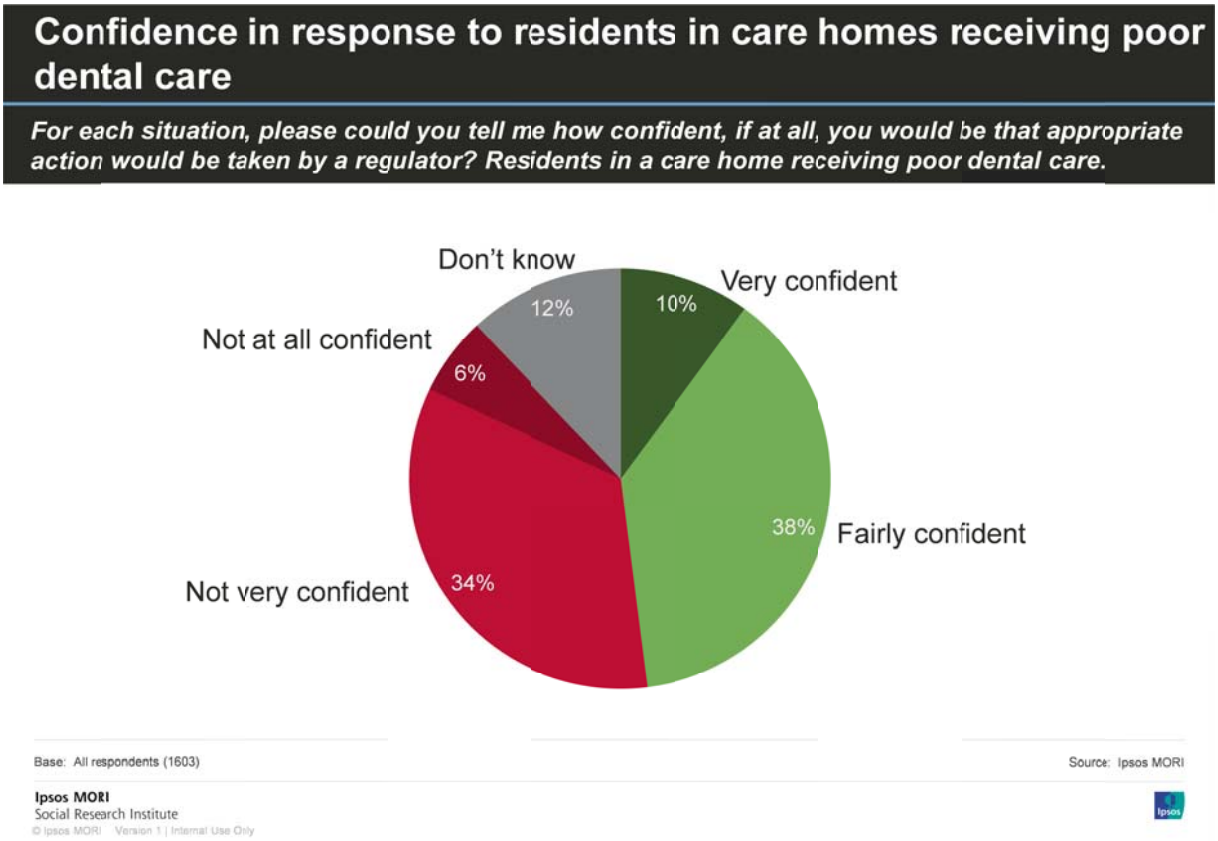
Participants were asked what disciplinary action should follow if a practice had repeatedly overcharged for a service. As with other areas they explained that their precise view would depend on the circumstances. If the offence had been relatively minor it was suggested that any additional cost should be paid back. In addition, some felt that a small additional compensation payment could be made to the patient. For example, a dentist practice could provide the patients' next treatment free of charge. Participants who had this assumption also believed that efforts should be made to stop this mistake happening again.

Participants were more concerned about deliberate and systematic overcharging for treatment. There was a belief that this would be a much more serious event and that disciplinary action should take place, with the final decision depending on the extent to which this practice had taken place.

> ***"They should get in there, stop it and refund the patient…. they should tell them that if they do it again they will pull their licence"***
>
> (Male/ Age 45 plus/ Social Grade B)

Poor dental care provided in a care home

Just under half (48%) the public is confident that appropriate action would be taken by a regulator to address a situation where residents in a care home were receiving poor dental care, including just ten per cent that are *very* confident. Almost as many are not confident (41%), including six per cent who say they are 'not at all' confident.



It may be of particular importance to the GDC to note that older people are more sceptical about the regulator's ability to address such a situation. For example, one in eight (12%) people aged 55-64 are *not at all* confident – a figure that is twice the average. Among those aged 65 or over, one in six (16%) say they 'don't know' if appropriate action would be taken. Negative views are most clearly held by those in the highest social grade; among those in social grade A, three in five are not confident and among social grade B almost half are not (60% and 46% respectively).

Those taking part in the qualitative research agreed that the thought of care home residents receiving poor levels of dental care would be very concerning as it would mean that potentially vulnerable people are being discriminated against, and that dental professionals are not acting in a professional way. It is worth noting that recent stories such as safeguarding concerns around Winterbourne View have meant that the safety, care and wellbeing of people using care homes are salient issues amongst the public.

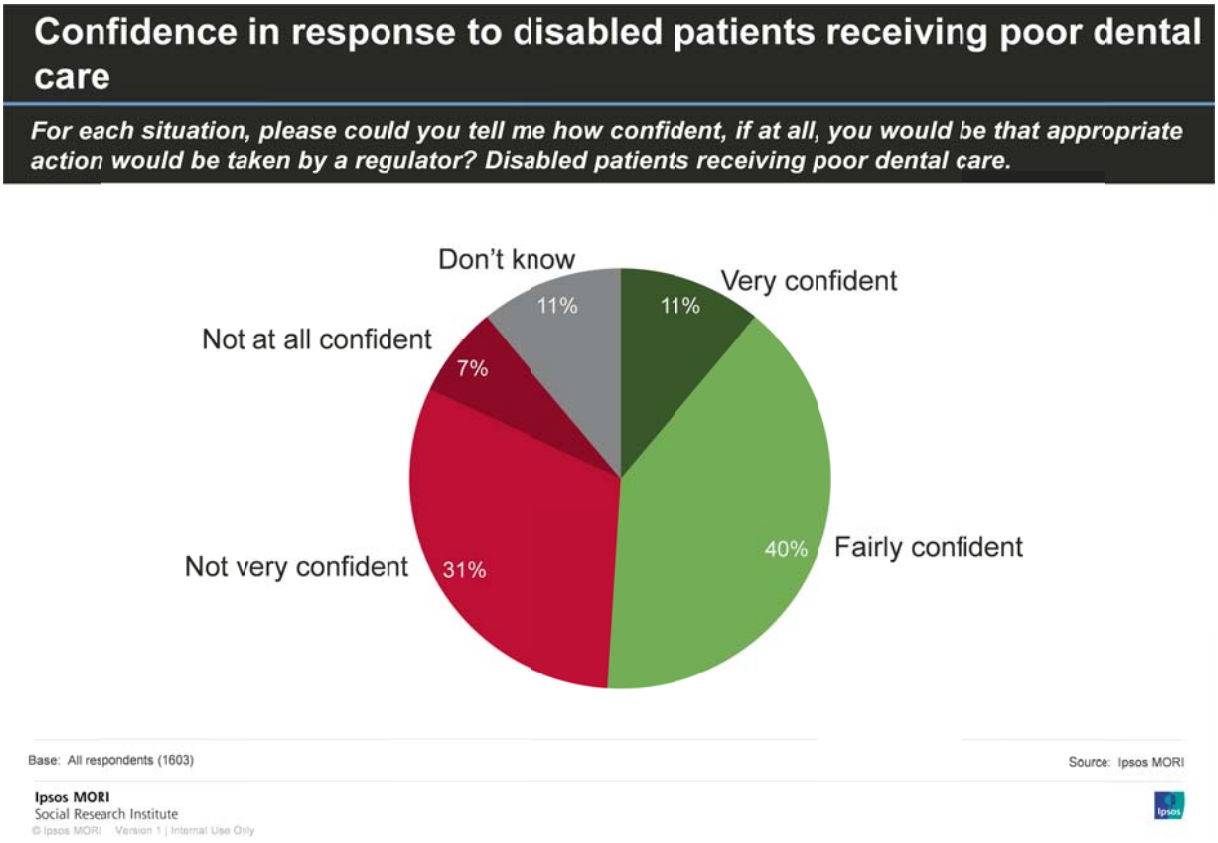
While participants felt that disciplinary action may be necessary (including the option of dental professionals being struck off) there was also a belief that any action should be proportionate and that dental professionals should not be unduly punished for minor, unintentional mistakes when the provision of further support or training opportunities may be more suitable. For example, one participant suggested that some dental professionals might

not have the soft skills necessary to fully understand the needs of care home residents. In this case, further training may be helpful, or it may be more appropriate for that person to continue to work as a dentist but not to work with care home residents in the future.

> ***"Well they should be made to retrain and if they not going to be retrained, then they should be struck off."***
>
> (Male/ Age45 plus/ Social Grade C2)

Disabled people receiving poor care

The scenario involving disabled patients receiving poor care is seen in a similar way to that of the care home scenario. Just half (51%) the public is confident that appropriate action would be taken by a regulator to address a situation where disabled patients were receiving poor dental care, including eleven per cent who are *very* confident this would happen. A significant minority (38%) is not confident this would be the case, including seven per cent who are 'not at all' confident.



Lack of confidence is marked among those aged 55-64 (49%) and in social grade A (55%). There are also national differences; in Northern Ireland and Scotland large minorities say they are *not at all* confident (20% and 14% respectively). By contrast, just one in three people in Wales and in the North, Midlands and London are 'not confident'.

Participants felt that the issue of disabled people receiving poor care was very similar to that of care home residents receiving poor care. As a consequence they believed that the same disciplinary actions should apply to both audiences. As with care home residents, people described extreme cases as being cases when a large number of incidents had taken place or when dental health professionals had intentionally provided poor levels of care. In such cases people felt it was legitimate for dental professionals to be struck off.

> ***"They should definitely be struck off and not allowed to practice again I think, and I am sure that that is illegal as well, so they would have to face criminal proceedings, if it was that extreme."***
>
> (Female/ Age 45 plus/ Social Grade C2)

A radiograph not being carried out

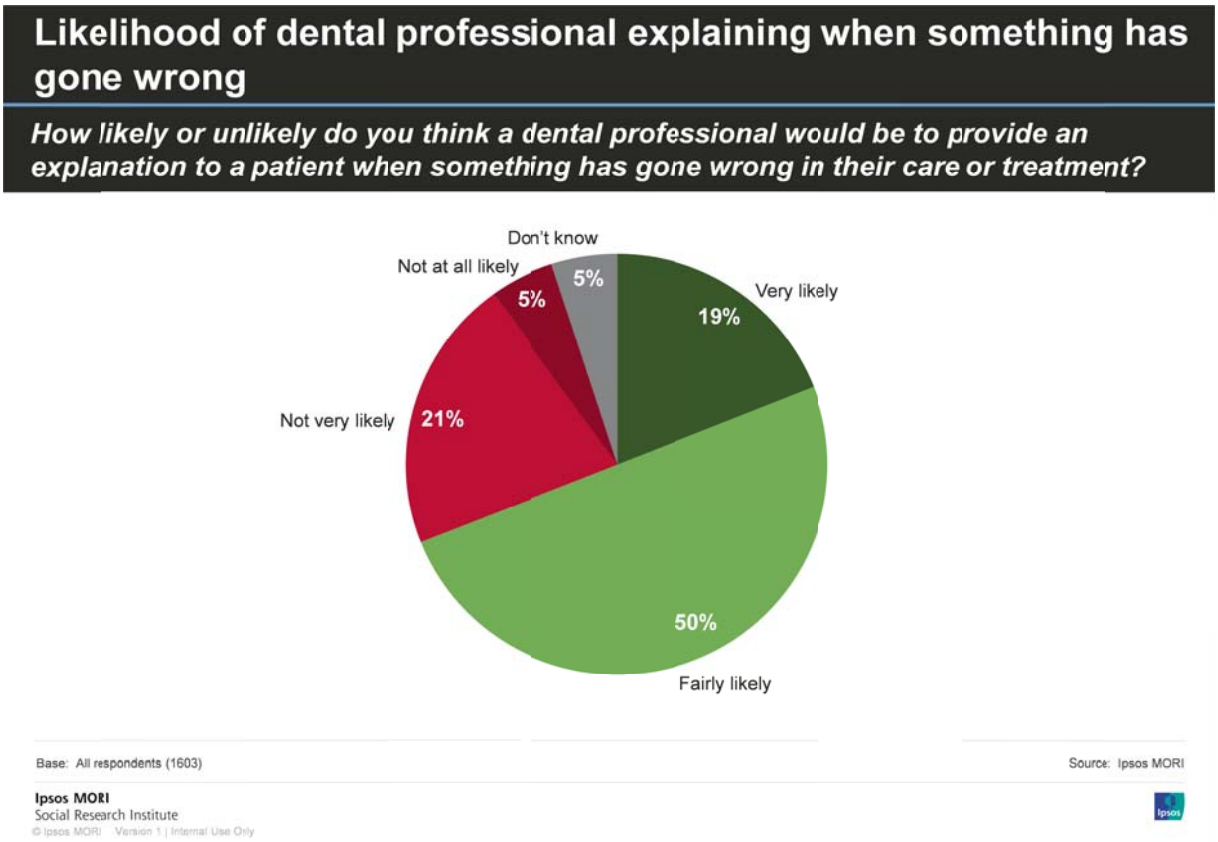
The final scenario was slightly different and was only used in the qualitative research. Participants were asked what their reaction would be if a radiograph was not carried out as part of a diagnosis and as a result a condition did not receive the appropriate treatment. As with the previous examples, participants were keen to ensure that any actions that were taken reflected the seriousness of the incident taking place. For example, participants believed that no formal action would be needed if a dental health professional forgot to provide an x-ray at the time of the appointment but later contacted the patient to apologise and offer an alternative time when this could take place (assuming that the patient was not charged for this additional appointment). While participants might find this irritating they believed that most patients would understand if a one-off mistake was made. On the other hand, if a dental health professional made this mistake a number of times, participants felt that the GDC should and would get involved as this would be a great deal more serious.

> ***"It would be a caution first and then if they kept on it would be two warning, like at work when you get a disciplinary where you're spoken to, and then you would be struck off…the General Dental Council would be responsible for this."***
>
> (Male/ Age under 45/ Social Grade D)

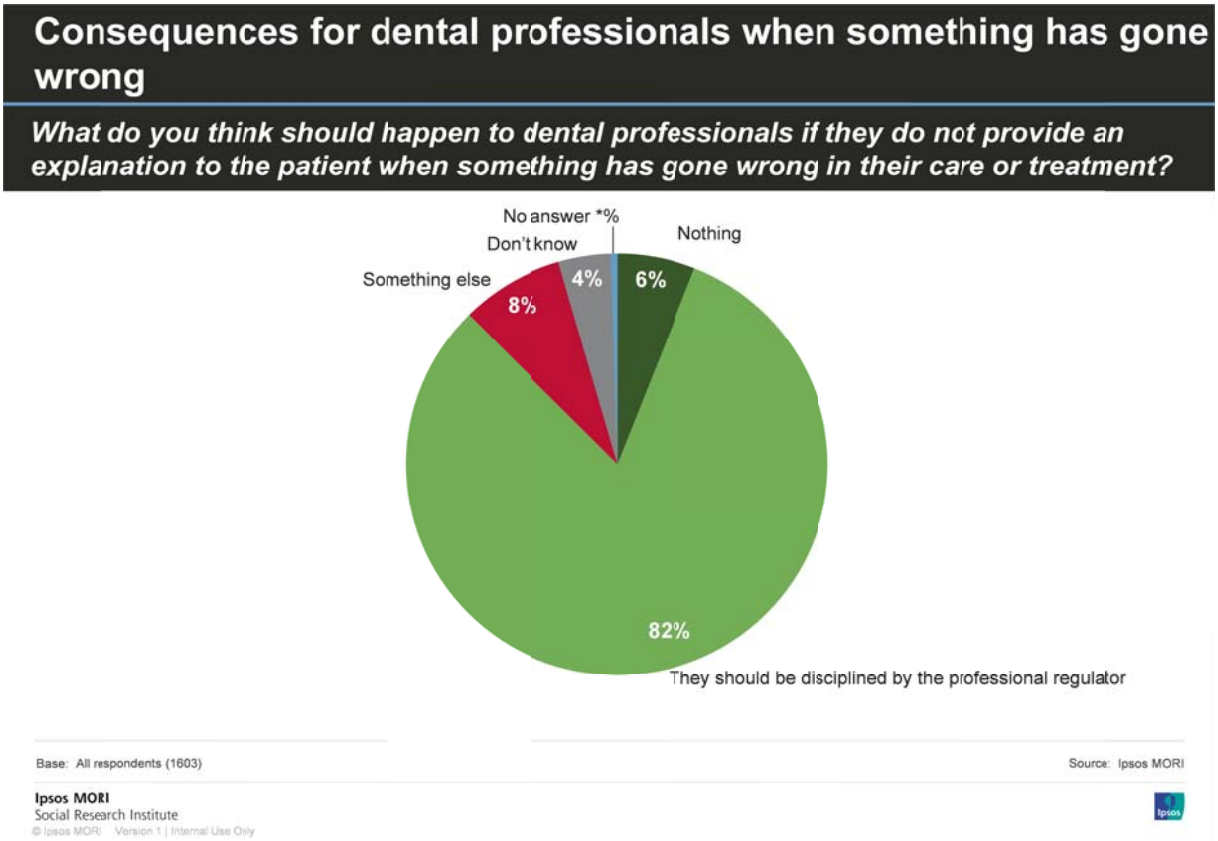
Some participants considered the potential patient outcome when weighing up their opinions about the example given. After prompting, some explained that they would be more upset if they suffered pain or a poor health outcome as a result of a dental health professional forgetting to take an X-ray, and as a consequence would expect the GDC to ensure that suitable disciplinary action takes place.

7.2 Providing an explanation

The public appear to have some faith in the way in which dental professionals will react when something does go wrong. Almost seven in ten (69%) people think it likely that a dental professional would provide an explanation when something has gone wrong in their care or treatment, including one in five (19%) who say this is *very* likely. The GDC cannot be complacent, however, since one in four (26%) say this is unlikely, including five per cent of people saying this is *not at all* likely.



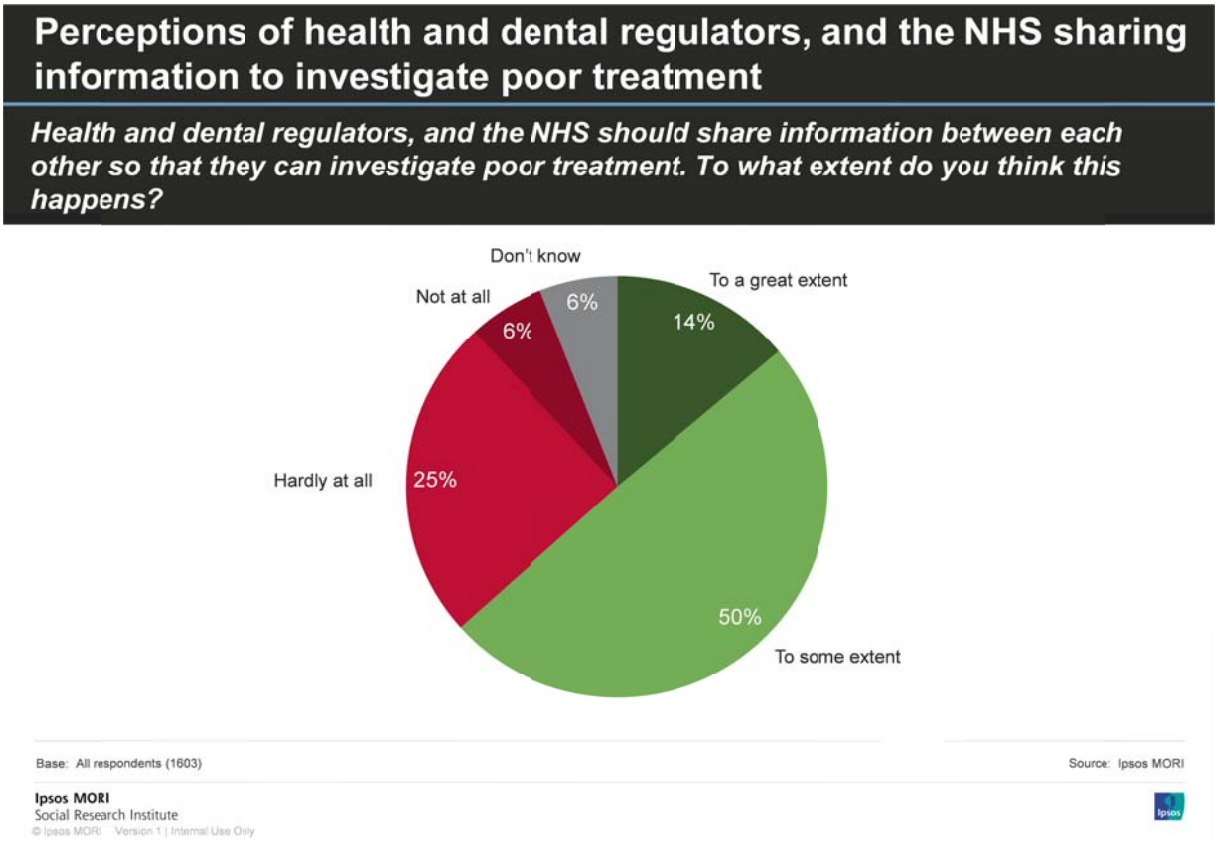
It is clear that the public feel this is important, as the vast majority (82%) consider that dental professionals who do not provide an explanation to the patient when something has gone wrong in their care or treatment should be disciplined by the professional regulator. Eight per cent believe the sanction should be 'something else', while six per cent do not think any action is necessary.



There are very few differences of opinion by sub groups on these two measures (above) with the exception of ethnicity where there are some significant findings. It is notable that people from minority ethnic backgrounds are far less likely to think that a dental professional would provide an explanation to a patient when something has gone wrong in their care or treatment than their white counterparts (57% vs. 71% respectively), this group is also four times more likely to say that the response to a professional not providing such an explanation should be 'nothing' (17% vs. 4%).

7.3 Sharing information between regulators

It was noted earlier in the report that people tend to have confidence in regulation. In line with this, almost two in three think that health and dental regulators (and the NHS) share information between each other so that they can investigate poor treatment (64%). One in four (25%), however, thinks this happens *hardly at all*, and six per cent *not at all.* Age is a key differentiator here with younger people aged 15-34 significantly more likely to think that information sharing happens to at least some extent (70%).



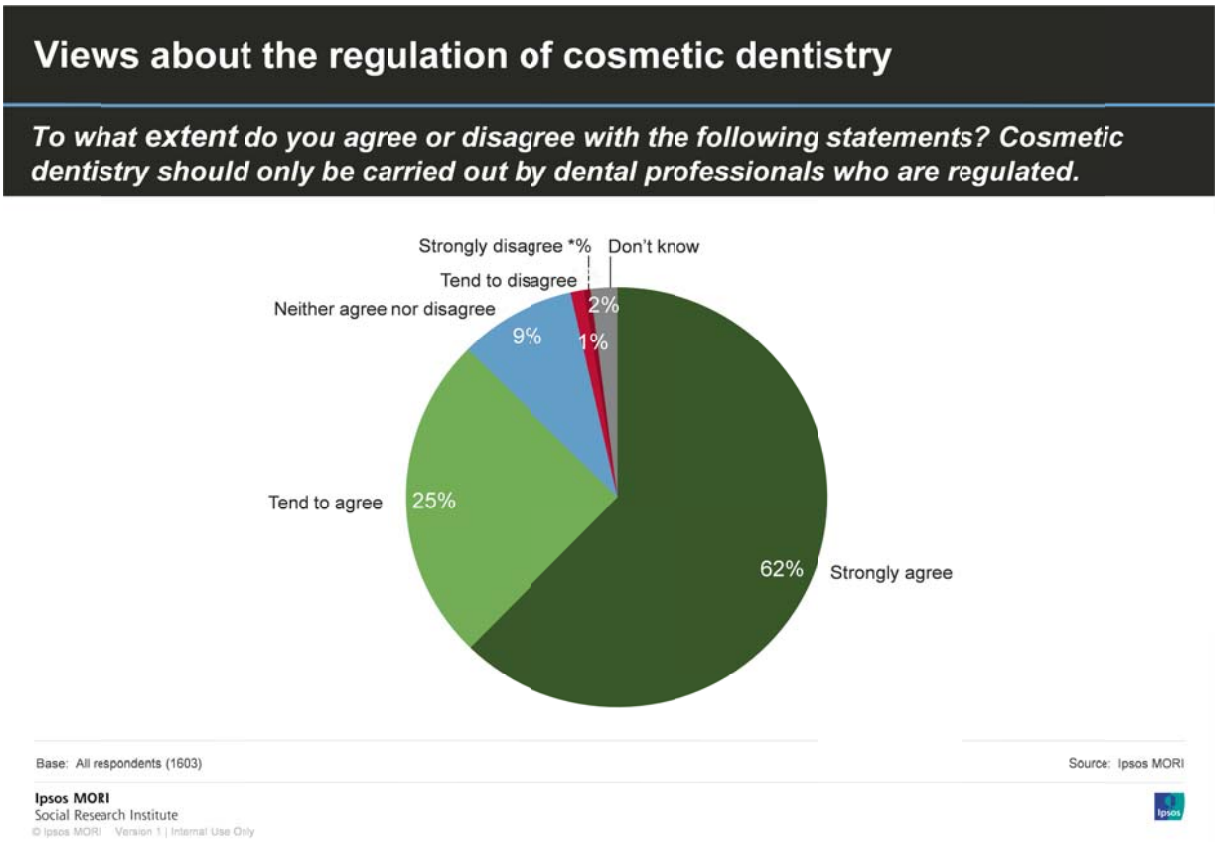
8. Topical policy issues

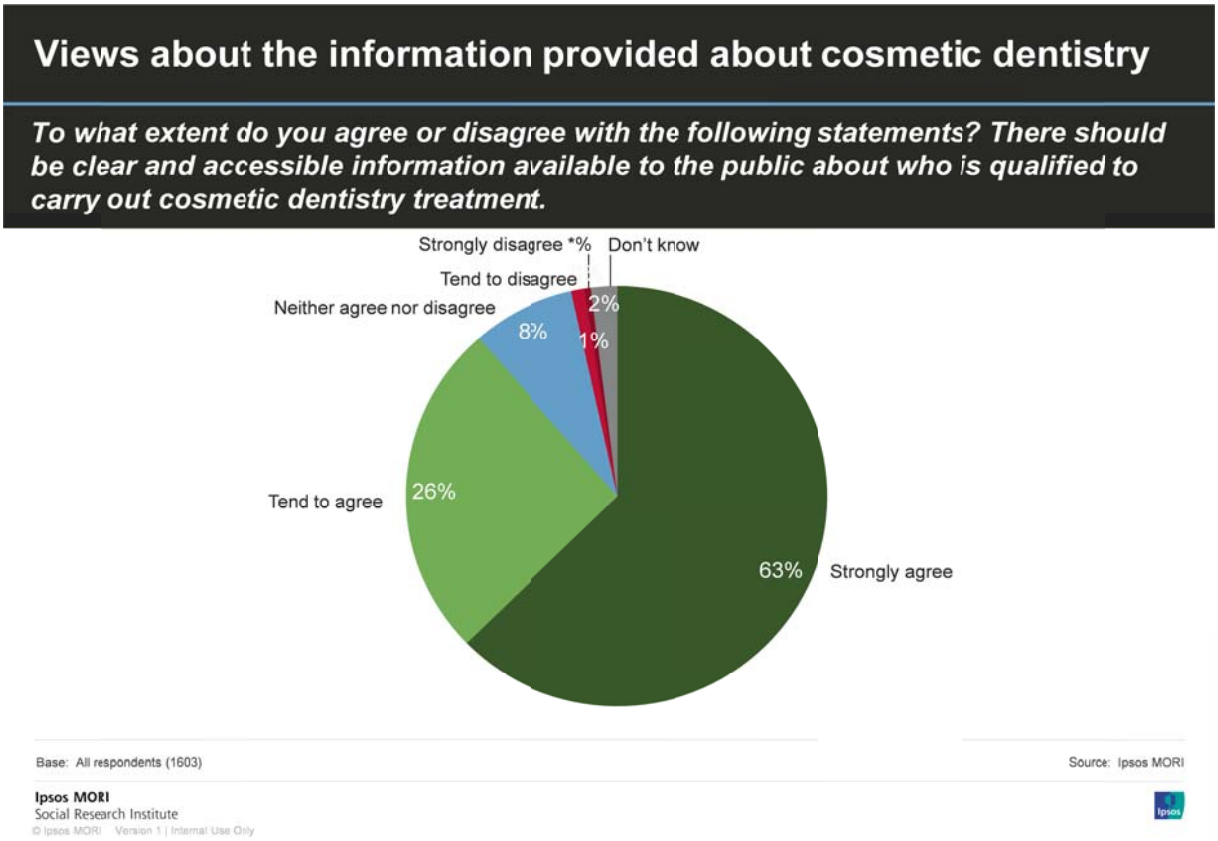
The survey covered a number of policy issues, which are discussed below. Further detail on each of these topics is given where appropriate in each of the following sub-sections:

- Cosmetic dentistry
- Specialists
- Overseas dental professionals
- Dentistry as a business

8.1 Cosmetic dentistry

The vast majority of people believe that cosmetic dentistry should only be carried out by dental professionals who are regulated (87%) and that there should be clear and accessible information available to the public about who is qualified to carry out cosmetic dentistry treatment (89%). Among these, the majority *strongly* agrees with the two propositions (62% and 63% respectively) and just two per cent of the public disagrees.





While across all population groups, there are consistently few people who disagree with these statements about cosmetic dentistry, the strength of opinion varies between groups.

- Women are more strongly supportive of regulation and access to information (65% women *strongly* agree with either statement; men 59% and 60% respectively).
- People aged 35-54 are more strongly supportive of regulation and access to information (68% and 70% *strongly* agree) than other age groups.
- Those in social grade AB are more strongly supportive of regulation and access to information (72% and 74% *strongly* agree) than other social class groups. A higher proportion of people in social grade DE express no opinion either way (17% and 11% respectively).
- People living in Northern Ireland, Wales and the South of England are more strongly supportive of regulation (81%, 76% and 69%% *strongly* agree) and access to information (78%, 79% and 68%) than people living in the rest of the UK.
- People of a minority ethnic background are more likely to express no opinion either way about the need to regulate cosmetic dentistry (25%), and they are much less likely than those from a white background to *strongly* agree with the call for clear and accessible information to be made available to the public (39% vs. 66% respectively)

- People who have recently and who frequently visit the dentist are more strongly supportive of regulation and access to information about cosmetic dentistry (68% *strongly* agree) compared with those who do not.

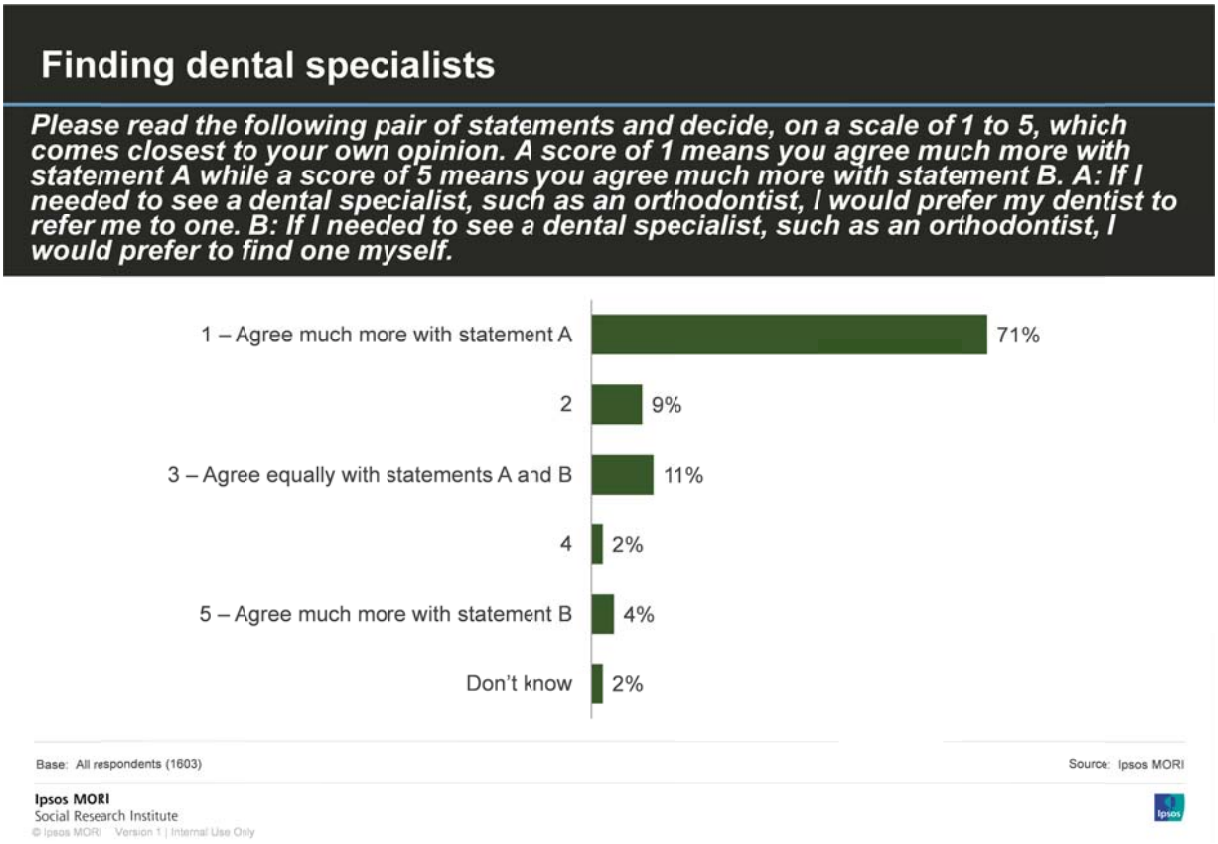
8.2 Specialists

Respondents were asked to read a pair of statements setting out two possible options for patient referral to a dental specialist. As it was expected that most people would find either proposition broadly acceptable, in order to determine the general preference for one *or* the other, they were asked to decide which of the two statements came closest to their own opinion using a scale of 1-5 to indicate preference. A score of 1 indicated closer agreement with statement A and a score of 5 closer agreement with statement B. The two statements were:

A) If I needed to see a dental specialist, such as an orthodontist, I would prefer my dentist to refer me to one.

B) If I needed to see a dental specialist, such as an orthodontist, I would prefer to find one myself.

Overall, seven in ten (71%) people indicated a preference for their dentist to refer them to a dental specialist (statement A, scale point ‘1’), with another 9% choosing scale point ‘2’. One in ten people (11%) agreed equally with statements A and B, while just 7% expressed a preference towards finding a specialist themselves (statement B, scale points 4 and 5).



While across all population groups few people express a preference for finding a specialist themselves, some groups were more clearly in favour of a referral from their dentist (scale point '1') while others were drawn to some extent to the other option (scale point 2 and above).

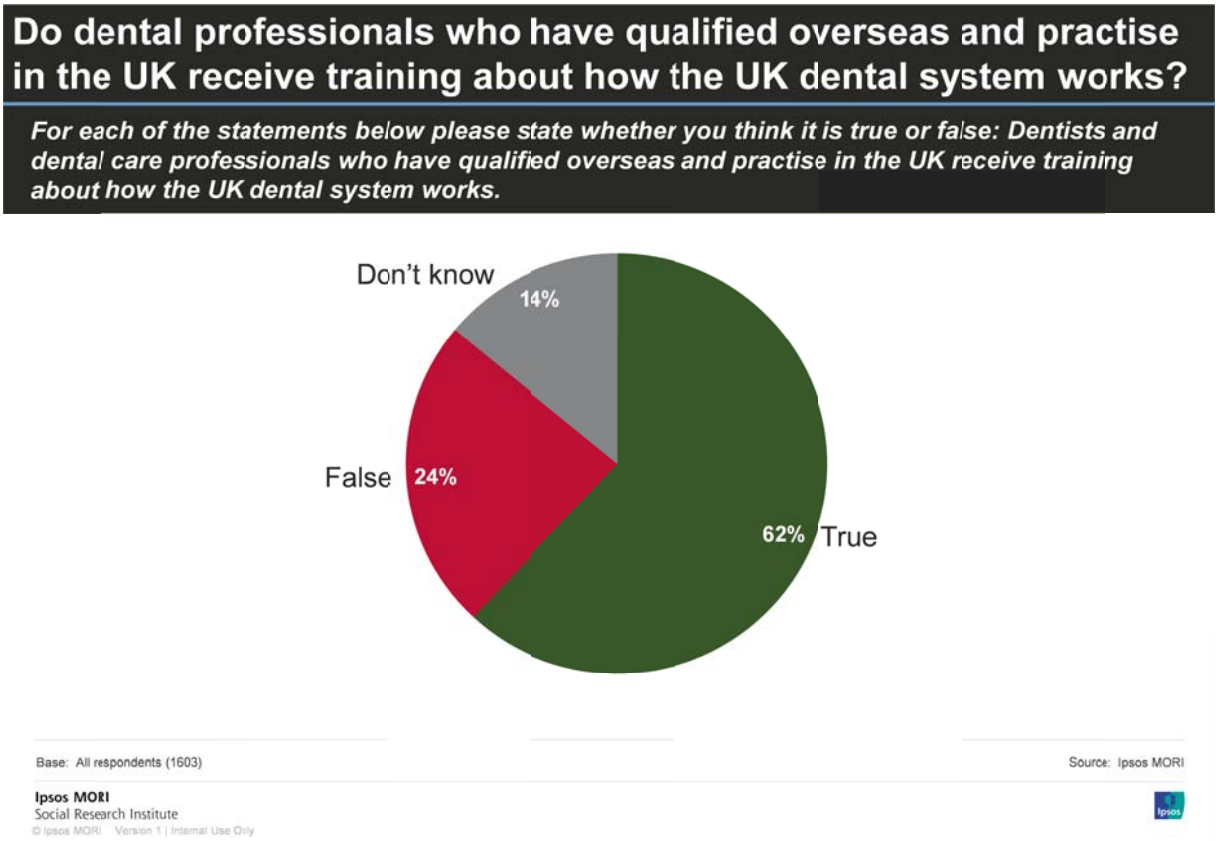
- People aged 35-64 are more clearly supportive of a referral from their dentist (77%) than other age groups.
- Those in social grade A are more clearly supportive of a referral from their dentist than other groups (87%). A higher proportion of people than average in social grade C1 find both options equally appealing (17%).
- People living in Northern Ireland and the North of England are more clearly supportive of a referral from their dentist (81% and 76% respectively) than people living in the rest of the UK. In the Midlands and London a higher proportion of people than average find both options equally appealing (15% and 18%). In Wales, ten per cent expressed a preference towards finding a specialist themselves.
- People of a minority ethnic background are more likely to find both options equally appealing than their white counterparts (27% and 9% respectively).

- People who have recently and who frequently visit the dentist are more clearly supportive of a referral from their dentist (78%) compared with those who do not.

8.3 Overseas dental professionals

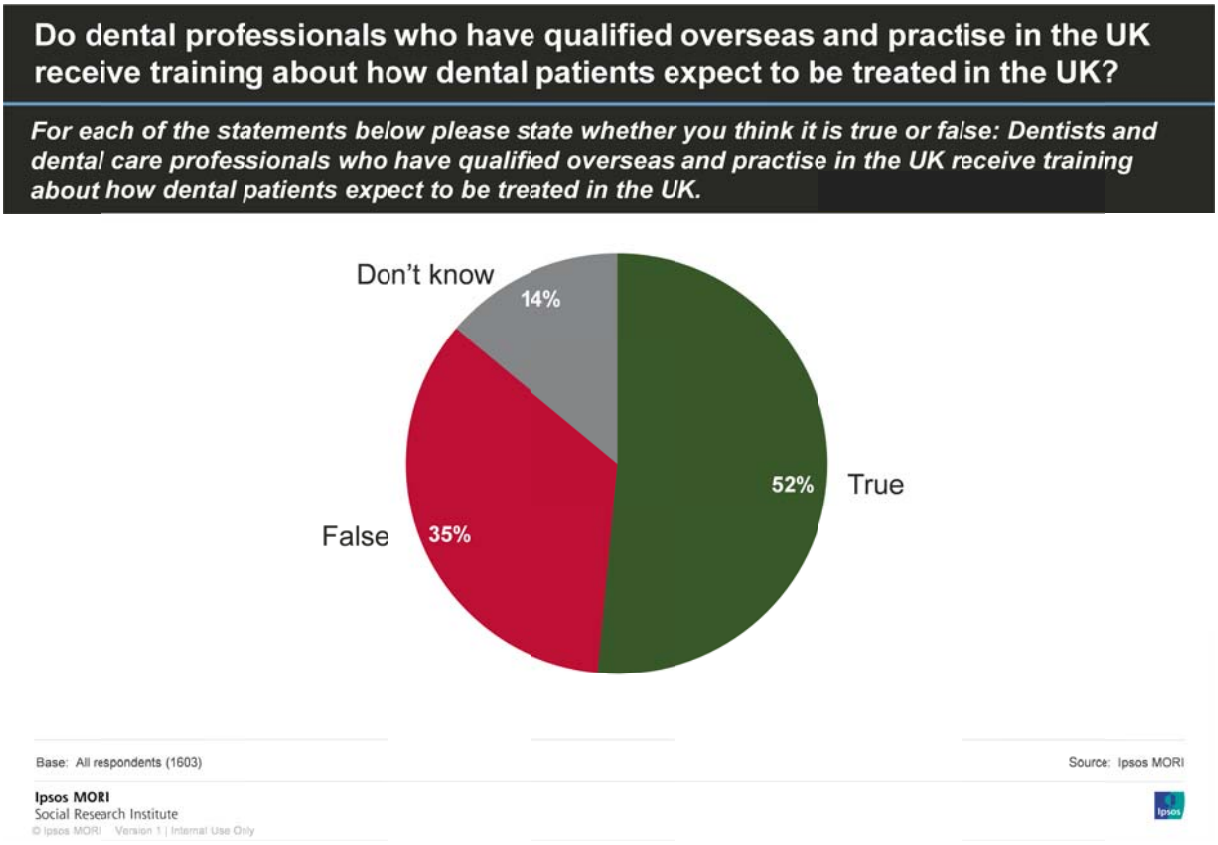
Training in the UK dental system & patient care

Three in five (62%) people think that dentists and dental care professionals who have qualified overseas and practise in the UK receive training about how the UK dental system works, and one in four (24%) does not.



Those aged 55-64 are most likely to disagree (33% 'false') while those aged 65+ are more likely to say they don't know (22%).

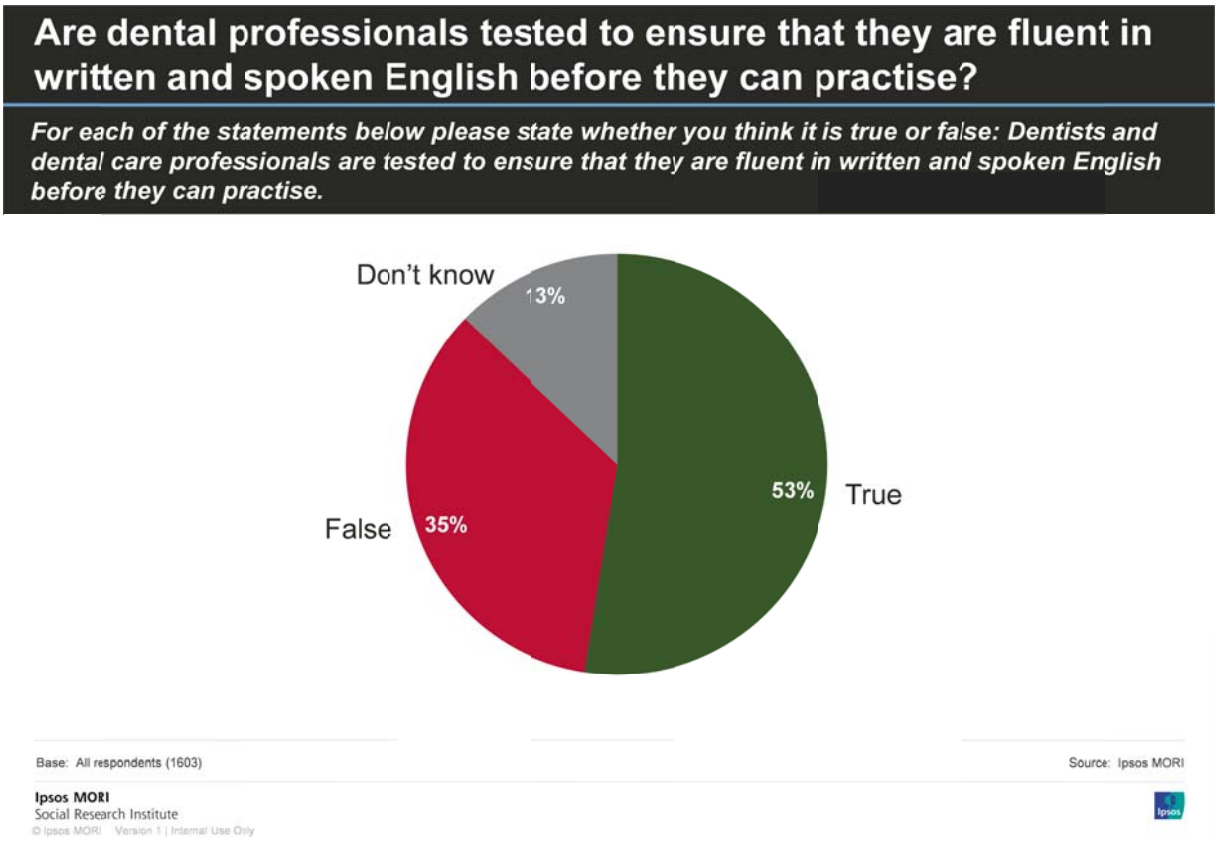
In contrast, just half (52%) the public thinks dentists and dental care professionals who have qualified overseas and practise in the UK receive training about how dental patients expect to be treated in the UK. One in three (35%) thinks this is not the case.



Age is a key driver of opinion; among those aged 15-34 three in five (60%) affirm this view, compared with less than of half those who are older (48% those aged 35+). Those from an ethnic minority background are more likely to say this is true than their white counterparts (59% vs. 51%). Attitudes are also moderated by patients' access to dental care; those accessing NHS services are more likely to say overseas professionals receive training about how dental patients expect to be treated in the UK compared with private patients (56% vs. 42% respectively).

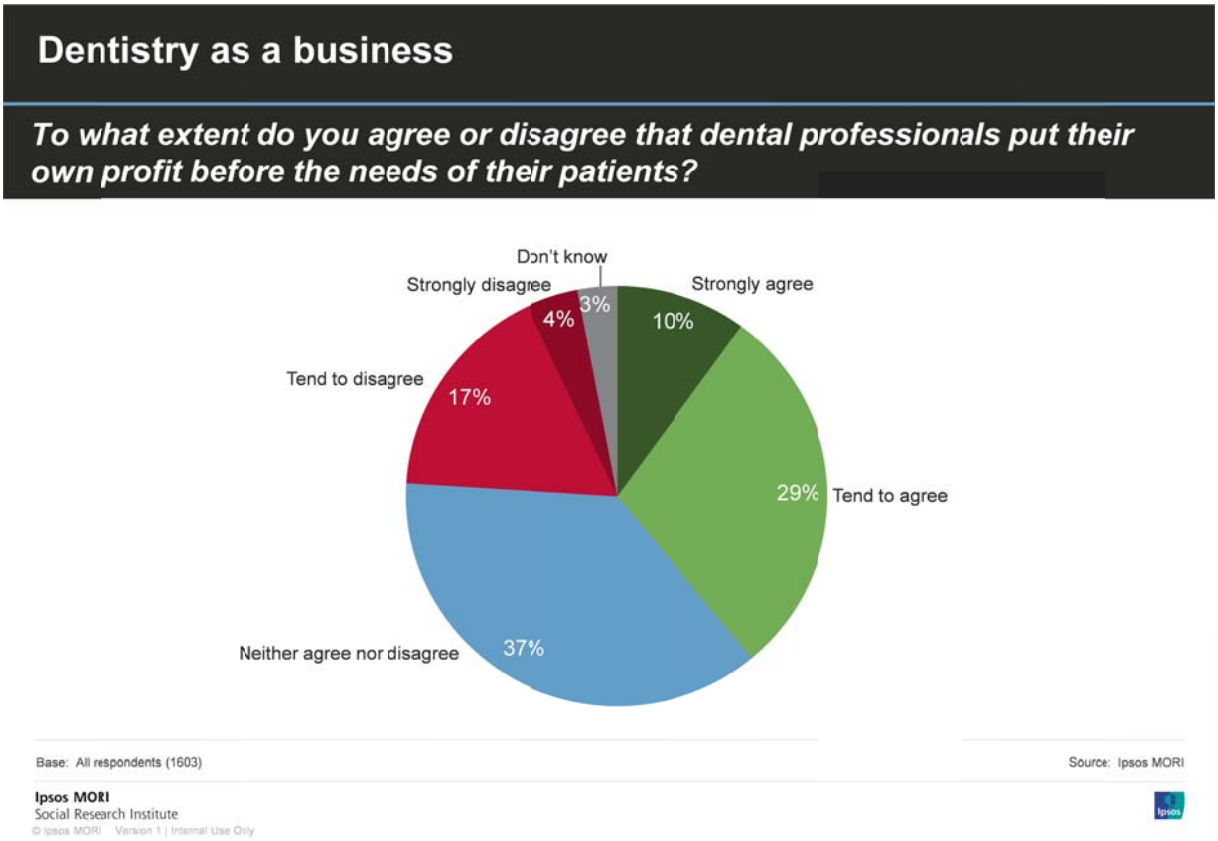
English language ability

Half (53%) the population believes that dentists and dental care professionals are tested to ensure that they are fluent in written and spoken English before they can practise, while one in three (35%) does not. The most sceptical are in the age range 45-64 where over two in five (43%) think this is not the case.



8.4 Dentistry as a business

The balance that dental professionals need to strike between caring for their patients and running a successful business was explored in both the quantitative and qualitative research. Two in five (39%) people believe that dental professionals put their own profit before the needs of their patients, including ten per cent who *strongly* agrees. Only one in five (22%) people disagree, though it is notable that a large proportion expresses no opinion either way (37%) perhaps suggesting that many people expect the profession to be run as a profit-making business or that they do not have sufficient knowledge to be able to judge.



There are certain groups within the population who are more likely to think that dental professionals put their own profit before the needs of their patients. These include:

- Men compared with women (42% agree vs. 36%)
- People aged 25-34 (49%) compared with other age groups
- People who are working as opposed to not working (42% vs. 35%)
- Those living in London (51%) compared with the rest of the UK
- People of minority ethnicities compared with their white counterparts (51% vs. 38%)
- People who have not recently visited the dentist and those who visit less often than once a year (47% and 52% respectively) compared with those who do (35% and 34%).

None of the participants in the qualitative interviews felt that their dentist had put their profit before their needs but many believed that in some practices this might occur, particularly where the cost of dental services is higher.

Participants defined putting profits before patients in different ways. Some suggested it could mean spending less time with an individual patient to allow professionals to see more people

in a single day, while others suggested it might mean committing fraud or actively harming patients for the sake of profit.

> ***"I think they're more concerned about making their money, I mean for example, people on, who pay for their dentists privately, they always get offered the most expensive fillings"***
>
> (Female/ Age under 45/ Social Grade E)

Most participants have mixed views about the existence of profit within dentistry. While they generally understood that dentistry is a business and appreciated that dental professionals have to earn a living that reflects their skills and training, there was little enthusiasm for this situation. There was also some scepticism that standards might be improved this way or that it would attract more talented candidates. Instead they preferred to think that dentists saw their profession as a vocation and would or should not be motivated by profit.

9. Dental patients as consumers

This chapter considers the findings from the six discussion groups to understand how the GDC might provide information to support consumerist behaviours amongst dental patients. The groups explored the following specific areas:

- perceptions of quality amongst patients at specific points in the journey
- trigger points for patients in cases of dissatisfaction
- information needs and the role of information and choice in changing patient behaviour.

As noted earlier, participants were classed as having a 'consumerist' approach if they were more likely to 'shop around' and make higher demands of their dental services and a 'traditional' approach if they were less likely to do so. The groups were used to explore and understand these types of attitudes and behaviours further.

9.1 Understanding and awareness of dentistry

Participants often had a limited understanding of the dental services that they were provided with and felt that this impeded their ability and confidence to judge the quality of dental services and to exercise choice.

> [when discussing information needs] ***'you're asking questions to understand why something's happened and then maybe having some sort of reference point where you can look at it and say that is kind of acceptable'***
>
> (Participant in Glasgow group, younger mixed)

Participants felt that there was a lack of clarity around which treatments can be obtained from the NHS and which are provided through private treatment. As a result they found choosing treatment options difficult. Some of those who could afford private treatment would follow the advice of their dentist without asking whether any other options might be available. In contrast those who could not afford private treatment often asked what the cheapest option might be.

Participants also felt that they did not have sufficient knowledge or experience to know what standards they should expect when visiting a dentist or receiving treatment. Many explained that they judged the quality of the service that they received by comparing it to the service they had received as a child. This meant that older patients could sometimes

have lower expectations than younger ones as a result of the improvements that had been made in recent years.

Some participants were surprised to hear that other people in their group had apparently had different experiences (for example different levels of explanation and pain) when receiving similar treatments. While they did note that there may have been good reasons for these differences, this served to emphasise their limited knowledge and understanding of their treatment.

Participants believed that there was often an imbalance of power between the patient and dentist. Dentists were considered to be the experts and patients felt they did not have the knowledge to feel confident about scrutinising dentists or questioning them about their treatment.

> ***"But how do we know what's acceptable? What should I expect, should I be in the chair longer?"***
>
> (Participant in Glasgow group, younger mixed)

In addition, participants often assumed that all dental practices would be of a certain (high) quality, as dentists would not be 'allowed' to provide services otherwise. This perception discouraged some participants from 'shopping around' for a good dentist as they felt that there was little reason to do this.

9.2 Defining high quality services

Participants struggled to judge high quality as a result of their limited knowledge about dental care and their limited exposure to dentists (often only visiting them occasionally). As a result, it was common for participants to focus on those aspects that were most visible or obvious to them in considering the quality of the care that they received.

Participants particularly valued having clarity around the cost of the treatment that they were receiving. Those who believed that they had received high quality services often believed that they had been charged a fair price, and had been given a clear explanation around issues such as whether they needed immediate treatment or treatment could be delayed, and whether any potential treatments had been suggested for medical or cosmetic reasons.

> ***"My dentist, if I'm having treatment, will say this is kind of what's going to happen following on from this treatment so you always get straight***

away this is kind of how much it's going to cost you and how they'll be billing you."

(Participant in Nottingham group, younger mixed)

The appearance of the dental team and practice was also considered an important indicator of the potential quality of the treatment that they were providing. For example, some explained that they would be unwilling to go to a dental practice where the reception area was dirty as they would be concerned that the dental tools might not be hygienic.

"You don't want to go somewhere dirty"

"Don't want something unsterile"

(Participants in London groups, older mixed)

The behaviour of the dental team was also considered important, with a good quality practice being described as one in which dentists and dental care professionals and reception staff were sympathetic, respectful, tolerant, polite and understanding.

Other priorities for patients included having flexible opening times, minimal waiting times, and (in some cases) the opportunity to use a variety of services such as dentists and hygienists.

Participants found it particularly difficult to define the quality of the clinical treatment, as they felt they did not have the relevant expertise. As such they focused on issues such as pain and comfort levels, whether dental professionals took a preventative approach, and the extent to which they believed that treatment was only provided when necessary.

"My policy would be to engage with a centre that had personal skills, how they treat their patients, you know do they recommend treatment that's necessary or is it additional, you know are you getting kind of value for money."

(Participant in Glasgow group, younger mixed)

9.3 Trigger points to complaining

Participants were asked to consider the 'trigger points' that might cause them to consider taking action if they were dissatisfied with the service received, including complaining or leaving their dental practice. Participants also discussed less formal forms of interaction such as leaving feedback or comments. While participants were often conflicted about what might prompt them to complain or take any further action, across all groups a number of key themes emerged. Each of these factors was linked to whether or not a person would take action, and what form that action might take.

One-off experiences vs. repeat experiences:

Respondents showed concern that leaving negative feedback or complaining about a one-off experience may not be fair to the dental professional.

> "***The first time he misses something, you're like all right, fair enough, it was one wee accident. And if it happens over and over again, you'll going to go, this guy does not know what he's doing…***"
>
> (Participant in Glasgow group, older traditional)

A number talked about having made mistakes at work and related this experience to dental professionals saying that they would not wish to be penalised for something that was an accident. Many felt that it was important to give dental professionals a second chance. Where an incident reoccurred participants felt that it would be at this stage that they would seek some form of action to be taken. There was a definite feeling of wanting to be sure of a situation before escalating it to a position where the consequences could be much more serious for the dental professional.

Severity of incident:

Closely linked to the repetition of incidents, was the severity of the incident. Here if the incident was considered severe enough participants suggested that they would not wait for repetition but would take action immediately. Similar to understandings of serious wrong doing, participants suggested that an experience where pain was felt and/or disfigurement involved would be classed as a severe incident. Interestingly, many said that they would expect some level of pain when they went to the dentist and so to complain they would have to feel high levels of pain and/or have pain for a number of subsequent days:

> ***"You kind of go expecting it to be a bit painful and to not be the nicest experience so as long as you're not actually hurt in any way, like really***

> ***hurt or something really goes wrong you kind of think well yeah that was all right, I was satisfied with that"***
>
> (Participant in Nottingham, older consumer)

The also talked about a severe incident involving irreparable damage:

> ***"I think, I mean if there was terrible damage, I mean if it was repairable then you sort of keep it local, but if it was irreparable and it's caused you pain, etc, financially and physically, then it would be escalated."***
>
> (Participant in Glasgow, younger consumer)

In addition, while participants suggested that poor communication skills showed poor practice, there were unlikely to take this type of complaint further than speaking to the professional personally.

Personal experience vs. hearsay

There was also a feeling that participants would have to experience an issue personally to force them to act. For example, when discussing a disabled patient receiving poor care and possible response to this, participants suggested that it would have to be a member of their family or a close friend for them to take any action. This was especially true if they themselves were experiencing satisfactory treatment:

> ***"If it's me and I'm getting good service and I've got no proof or evidence of anything, I'd just carry on as normal."***
>
> ***"If you haven't experienced it yourself, you know, if it's happened to certain people then they're the ones that need to take action on it, not necessarily you."***
>
> (Participants in Nottingham group, younger mixed)

9.4 Type of action taken

Having discussed what would trigger participants to act; participants were further probed about what action they might take.

The majority of participants said that they would either complain to their dental practice or would vote with their feet and leave the practice.

> ***”People may look to move or may just kind of ignore it and deal with it but at worst it’s going to be complaining in house”***
>
> (Participant in Nottingham group, younger mixed)

In some cases, leaving was seen as an easier alternative to making a complaint (where choice existed). In addition, some believed that a formal complaint, or even leaving more informal negative feedback would harm their relationship with their dentist, and were concerned that it might resulting in them receiving poor care in future visits.

> ”***I think it wouldn’t be easy to make a complaint, because it’s easy just to transfer, I think if something’s happened, unless you’re really irate about it then you will phone up and complain, but as time goes on… maybe you would just change dentists and move on”***
>
> (Participant in Glasgow group, younger mixed)
>
> ***“I haven’t got the courage to complain… because I think the dentist that I go to there might be repercussions”***
>
> (Participant in Nottingham group, older consumer)

Where respondents said the appropriate response would be to complain to the GDC (having been told who the GDC was) this was in terms of earlier discussions relating to the severity of the case. Only very severe cases, defined in terms of repetition of incidence and experience of physical, financial or mental pain and distress, were seen as likely to prompt the patient to escalate action up to the GDC:

> ”***Well I think you should go elsewhere but if they did something really bad then you should go to the GDC. It’s hard to know what is serious. Maybe if they cut a nerve or something that really damaged that would be when the GDC should be involved”***
>
> (Participant in Nottingham group, younger traditional)

As noted earlier, there were some key barriers in relation to judging good quality care. In fact, a number of participants raised similar barriers that may prevent them from taking any action, and for a very limited few this included serious negligence:

- Feeling they didn’t have the right knowledge of dentistry to know if they had been treated unacceptably:

> *"If you come out of the dentists and you are not in pain then how do you know that they haven't done a good job?"*
>
> (Participant in London group, older mixed)

- Fearing that there might be repercussions if they did take action:

> *"So you complain to the dentists they might not take very good care of your teeth"*
>
> (Participant in Glasgow group, younger mixed)

- Not knowing how to complain if they wanted to:

> *"You complain but who do you complain to. Not know who to complain to. You have nowhere to start complaining to."*
>
> (Participant in London group, older mixed)

Participants suggested that they saw a positive role for the GDC to help encourage non-complainers to complain. A number talked about the role the GDC could have in informing these individuals to give them the confidence to complain. In particular, they suggested that the GDC produce material which would allow patients to develop a good understanding of acceptable and unacceptable treatment.

9.5 Patients' information needs

Participants believed that there was a need for more information to be provided about dentistry. At a general level there was a demand for further information around the cost of treatment, and for information to be provided around the quality standards that all patients should expect to receive. At a local level, participants also suggested that they would like more information available on specific dental treatments and services available in their local area, and on the likely waiting times and availability of appointments. The quality of the advice around treatment options provided to patients by dental professionals in their local practices was also important. It is worth noting that the GDC has published documents designed to inform patients about the standards that they should expect.[16] Participants did

[16] http://www.gdc-uk.org/Membersofpublic/standardsofcare/Pages/default.aspx

not mention these in the groups or depths suggesting that there is currently limited awareness of them.

As noted earlier, there appears to be some appetite for the introduction of a rating system for dental practices but there was no clear consensus around how the scoring system should work. For example participants had different views as to whether patients or the GDC should be responsible for scoring the dental practices; some thought there was a place for both. The evidence from the groups suggests that patients would be most likely to use the rating system when changing dentist, and, in many cases, only when recommendations from friends and family were not available. While many believed that a rating system would only provide them with a partial understanding about the quality of the service available, participants felt that dental practices with particularly poor ratings might struggle to attract new patients which could result in some closing down.

> ***"Sometimes one customer gives it a one and one person gives it a five, it can't be that different between two people, so that is always a risk that those aren't very effective because it just depends on the person."***
>
> (Participant in Glasgow group, older traditional)

Patients rarely spontaneously raised or mentioned the experience and disciplinary record of the professional treating them as an issue but after prompting, some participants recognised the potential value of this information.

In the London group some said that finding out their dentist had been investigated by the GDC would not affect their decision to continue to use a dental practice when they had had a history of positive personal experiences (echoing the findings in the previous section). However in Glasgow, media coverage about poor quality dentistry had encouraged people to seek more information about the dentists working in the area. Participants discussed searching the internet to see if their dentist or prospective dentist had been in the news for malpractice, and asking friends and family for their opinions of local dentists. Therefore, there was clear movement towards a more consumerist approach amongst these participants due to external factors.

There is also a need for more information about how and where to complain or feedback – as well as some reassurance that it is acceptable to complain. This is linked to the desire for more understanding of the quality standards that patients should expect to see.

> "***Provide some information to the patient stating that if they're unhappy with the service this is how you would go about complaining,"***
>
> (Participant in Glasgow, younger mixed)

9.6 The role of the GDC

While some participants had heard of the GDC, or at the very least believed that such an organisation was likely to exist, few had a detailed understanding of the organisation and the work that it does. As such, there was a general feeling that the GDC should do more to publicise its work. While it should be noted that participants in qualitative research are often keen to find out more about organisations once they have spent some time discussing their work, awareness raising will be important for the GDC if it is to empower patients in the future (see section 9.7).

Some participants emphasised the importance of the GDC (or other regulator) performing regular investigations of dentists using mystery shopping or Ofsted style inspections, and were keen for visits to be unannounced. They also felt that these inspections should consider all aspects of quality (drawing on those areas discussed in section 9.2).

> ***"They should do something like the mystery shopper."***
>
> (Participant in London group, younger consumer)

Participants felt that the GDC or other regulators should actively search for signs of consistent poor services or malpractice and proactively follow up any cases where there is evidence suggesting that there could be problems.

Participants also suggested that the GDC should have an active role in protecting vulnerable groups who might not have the capacity or confidence to complain.

> ***"If you were abusing your power and your position and people in a vulnerable position then yeah I think that needs to be investigated."***
>
> (Participant in Nottingham group, younger traditional)

9.7 Empowering patients

Patients' current attitudes and behaviour

The groups provided further insight into the different approaches and attitudes that exist amongst patients.

Participants' attitudes or behaviours could be described as existing on a continuum. On one end were those who could be described as having a **traditional outlook** towards dental services. These participants often assumed that most services were of a similar quality and consequently had chosen to use the most convenient dental practice with little consideration of other factors. They also explained that they were unlikely to complain or change dentist unless they experienced a very poor standard of care.

On the other end of the continuum were participants who could be described as having a more **consumerist outlook.** They tended to be more proactive and demanding, and explained that they were more likely to shop around for services, and complain or change dentist if they thought there was a good reason. They were also more confident about providing feedback, and amongst the most enthusiastic about increasing patient choice.

It was common for participants to sit in the middle of the continuum having a mixed outlook that could change according to the circumstances that they faced. For example, some explained that they might be more demanding if they moved house and had to find a dental practice in a new area.

Are patients becoming more consumerist in their outlook?

Participants believed that patients are gradually becoming more demanding than they used to be, and more likely to provide feedback and take action. This was particularly noticeable in areas where there was a greater perceived choice of dental practice as a result of practices using advertisements to attract new patients.

In addition, there was some evidence that the increasing opportunities that patients and consumers have to provide feedback (such as by using NHS Choices) could be 'habit forming' as individuals become used to having more choice, and start to expect this service in dentistry.

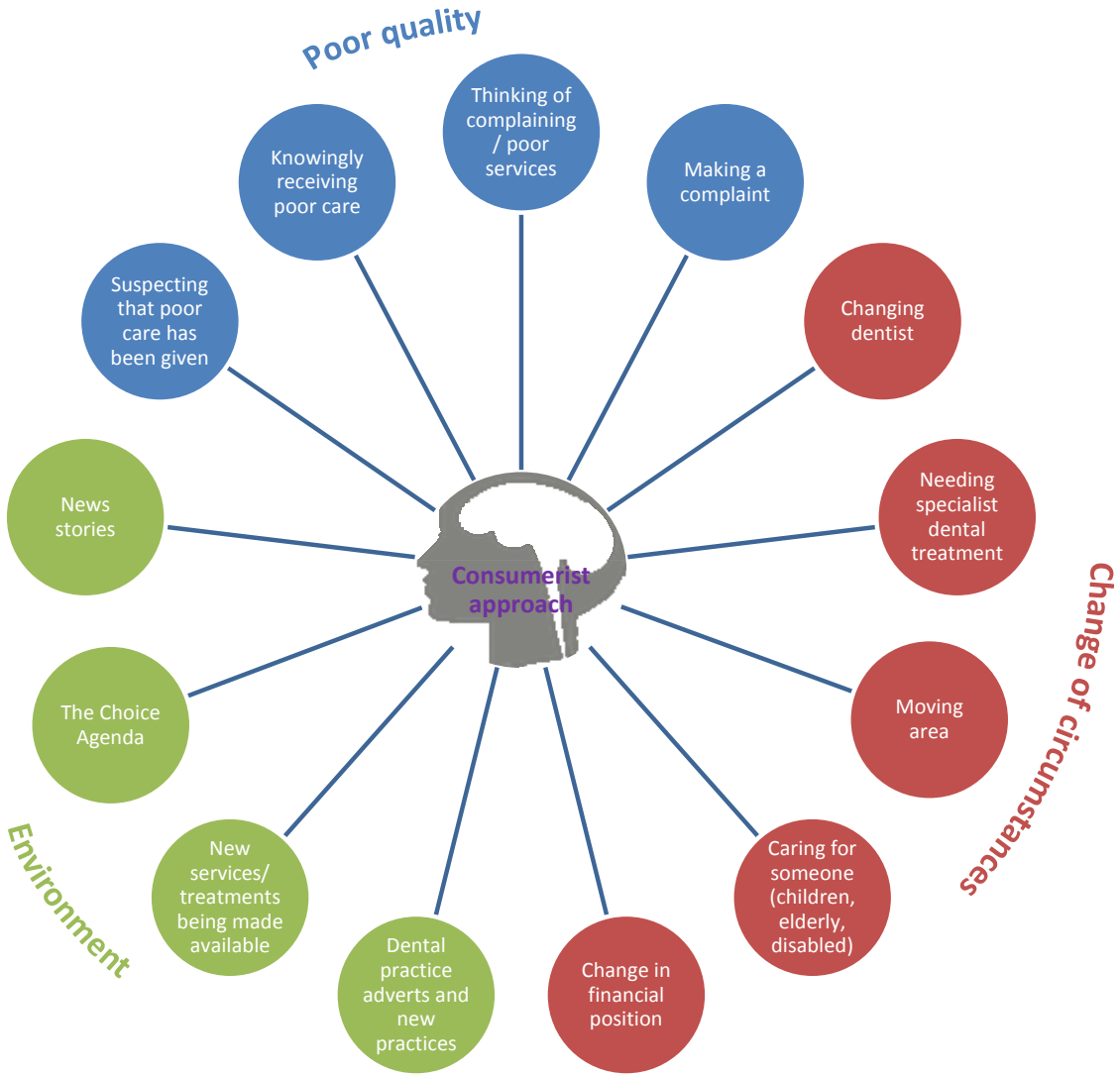
Despite this, the evidence from the groups suggests that this change could take some time to occur. Participants explained that there were a number of barriers preventing them from having a more consumerist outlook (as noted earlier).

Factors linked to consumerist behaviour

Participants suggested a number of factors that were linked to a more consumerist and proactive approach:

- those who were experiencing a **change in** their own **circumstances** or those of their family members were more likely to consider changing practice, or to demand more from the services that they received;
- those who had perceived **poor quality services** were also more likely to exhibit these behaviours; and
- the **wider environment** that dental professionals work in is likely to have an impact. For example, local news stories, and increasing competition may have encouraged participants in Glasgow to be more demanding of the services that they received.

The following chart shows a number of specific examples of each factor, which may lead to an individual taking a more consumerist approach. Of course, these are not mutually exclusive; one person may be influence by more than one factor at different points or even at the same time.


Poor quality
Thinking of complaining / poor services
Knowingly receiving poor care
Making a complaint
Suspecting that poor care has been given
Changing dentist
News stories
Needing specialist dental treatment
Consumerist approach
The Choice Agenda
Moving area
Change of circumstances
Environment
New services/ treatments being made available
Caring for someone (children, elderly, disabled)
Dental practice adverts and new practices
Change in financial position

Opportunities for encouraging more consumerist behaviour

The factors illustrated in the chart above present potential opportunities for the GDC to encourage, support and facilitate more consumerist behaviours amongst patients. However, patients' information and support needs will vary depending on where the patient sits on the continuum between a consumerist and traditional outlook and their situation at the time (whether they have received poor care, have experienced a change in circumstance or have been affected by the wider environment).

For example, some patients receiving poor care will simply require clear and accessible guidance on how to make a complaint (those with a consumerist outlook), whereas others, who are more traditional, will need far more reassurance that the care they have received is not acceptable, and that a complaint is warranted.

In addition, any information will need to take account of the barriers noted earlier in section 9.2. For example, participants noted an imbalance of power between themselves and the professional, suggesting that they will need more information to feel that they are able to challenge the dental professional about the care they have received.

The opportunities to encourage consumerist behaviour and/or to support and empower patients in their choices are outlined below in relation to each factor.

Change of circumstances

Patients felt that they were most likely to change their behaviour as a result of their (or their families') circumstances changing. At this point, they suggested they would be looking for information that would enable them to make a more informed choice. For example, they suggested the need for a range of information about each practice:

- more transparent information around pricing;
- information about waiting times;
- feedback from patients;
- independent assessment (from the GDC or other regulator) about the service.

This may also be an opportunity to provide patients with information about the standards expected of any dental practice, particularly given the lack of detailed understanding about dental services.
Participants suggested this information should be easily accessible at a local level (and not just on a central website). It was clear that awareness of how to access this information (or whether it even existed) was low.

However, the reliance on personal recommendation (as found in the quantitative survey) means that some patients will still not seek out this type of information. Therefore, they would only encounter this type of information once they visit a practice that has been recommended to them. Once they do have access to it though, they might then use it alongside other forms of evidence.

Poor Quality

Participants provided examples of issues that would encourage action such as making a complaint or leaving a practice (as discussed earlier). These could vary by individual. As noted above, some patients will need far more support and guidance than others when taking action as the result of poor care:

- Some patients will simply need clear and easily accessible instructions on how to make a complaint or provide feedback (and the process).
- Others will need more clarity and reassurance as to the process with clearer signposting and (for some) the reassurance that they could raise anonymous complaints or comments.
- Some of these will need a great deal of encouragement to make a complaint, given their limited ability to judge whether the care received was acceptable – the GDC may need to consider how to provide clearer guidance on this to these patients. This will also include information on the standards expected of all dentists.

Finally, given the preference for many to leave the practice rather than make a complaint, some patients will need information about the choices available to them locally (as above).

Environment

While the GDC may not always be able control the wider environment and circumstances in which dental professionals operate, there are opportunities to be proactive as well as responding to events in a way that could encourage patients to exhibit more consumerist behaviours.

The evidence from the Glasgow groups where they had been a number of recent news stories around dentistry suggested that these can have a significant impact on participants' views and attitudes. The GDC and its partner organisations (such as the Care Quality Commission) could have a role in responding to these stories, and using them to provide additional information.

> ***"You need standards… You hear about all these horror stories in the newspaper, that someone had some teeth removed and there was nothing wrong with them and then the next day they were struck off the list, you know, so there needs to be… if somebody has a concern they can write it off to someone and it's taken seriously"***
>
> (Participant in Glasgow group, younger mixed)

There could also be opportunities for the GDC to make the news by proactively writing stories that illustrate how standards vary and raising the issue of patients choosing high quality services.

It is worth noting that participants felt that patients have a more consumerist outlook than they previously might have had in the past and that this trend is likely to continue. If this trend does continue it is possible that patients might start to demand more information as a way of ensuring that they can exercise more choice, and provide dental practices with feedback.

The chart and analysis provide suggestions for enabling patients to develop a more consumerist outlook. There are opportunities for the GDC to build on this through further research exploring current patient behaviour and choices and further opportunities to enable behaviour change.

10. Conclusions

This survey has generated a wide range of quantitative and qualitative data for the General Dental Council to consider. The final chapter of this report outlines some of the key findings.

Patient satisfaction with dental care is very high.

Nearly all of those who visit their dentist at least once a year are satisfied with their treatment. Satisfaction tends to be linked to the professionalism of the dentist and their communication skills, rather than their clinical qualifications.

There is strong confidence in the regulation of dental professionals.

There is an underlying assumption among the public that all dental professionals are qualified and fit to practise, otherwise they would not be allowed to do so. This is reflected in the powerful finding that only one per cent of people have checked whether or not the dental professionals they have used have had any disciplinary action taken against them, and there seems to be little appetite to do so.

Yet, there remains a lack of detailed knowledge about how regulation works.

People are unsure which body is responsible for regulation or the terms they use in reference to regulation. But these are not seen of high importance to the public, and do not affect their trust in the process. **Views do differ by different sub-groups**

Certain groups such as younger people, those from lower social grades and ethnic minorities, appear to have lower awareness and understanding of the GDC. Those from ethnic minority backgrounds are also less likely to have confidence in the regulation of dentistry.

There are high levels of faith that dental professionals will provide an explanation if something goes wrong.

Many people said that they felt if something went wrong their dental professional would provide them with an explanation, although those from ethnic minority backgrounds had less confidence in this than other groups.

There is some uncertainty that appropriate action would be taken by a regulator in cases of serious wrongdoing.

The public are divided about whether a regulator would appropriately address situations such as the repeated overcharging of patients or poor care being delivered to residents in a care home or disabled patients. The qualitative research suggests that there is limited knowledge about what form appropriate action would or should take.

There is some sense that dental professionals put their own profit before the needs of their patients.

People tend to think dentists are more concerned with business needs than GPs are for example. However, few were able to cite direct experience of this themselves and this opinion is not adversely affecting public perceptions of the profession at the moment.

There is some appetite for a star rating system, though views are mixed.

When choosing a new dental practice, location tends to be the most important factor, followed by recommendations from friends and family. Some would make use of a star rating system to help them choose a dentist. However, there is no consensus about what the ratings should be based on, or how they should be presented to the public. As such, some thought might have to be given to how to create a system that would have wide appeal.

There are opportunities for the GDC to support more consumerist behaviours amongst patients.

While patients appear generally happy with the information available to them about dentistry, there appear to be some opportunities for the GDC to provide information and support to encourage and facilitate more consumerist behaviours:

- when patients are undergoing a change in circumstances
- when patients have received poor care
- when patients are affected by wider environmental factors (e.g. local news stories).

There are some barriers to increased consumerist behaviours amongst patients.

Any information that the GDC produces will need to take account of and overcome some key barriers. For example, these include a lack of knowledge and understanding about dentistry and the service patients should expect, an imbalance of power and reluctance to question a

professional, the fear of repercussions and a lack of knowledge about the options open to them.

Appendices

Appendix A: Statistical significance

It should be remembered that a sample and not the entire population of adults aged 15 and over living in the United Kingdom has been interviewed. Consequently, all results are subject to potential sampling tolerances (or margins of error), which means that not all differences between results are statistically significant. For example, for a question where 50% of the people in a weighted sample of 1603 respond with a particular answer, the chances are 95 in 100 that this result would not vary more than plus or minus two percentage points from a census of the entire population (using the same procedures).

Indications of approximate sampling tolerances for this survey are provided in the following table. As shown, sampling tolerances vary with the size of the sample and the size of the percentage results (the bigger the sample, the closer the result is likely to be to the result that would be obtained if the entire population was asked the same question).

This survey used a quota sampling approach. Strictly speaking the tolerances applied here apply only to random samples with an equivalent design effect. In practice, good quality quota sampling has been found to be as accurate.

Approximate sampling tolerances applicable to percentages at or near these levels			
	10% or 90%	30% or 70%	50%
Size of sample on which survey result is based	±	±	±
100 interviews	6	9	10
200 interviews	4	6	7
300 interviews	3	5	6
400 interviews	3	5	5
500 interviews	3	4	4
600 interviews	2	4	4
700 interviews	2	3	4
800 interviews	2	3	4
900 interviews	2	3	3
1603 interviews	2	2	2
1609 interviews	2	2	2
1563 interviews	2	2	3

Different groups within a sample (e.g. men and women) may have different results for the same question. A difference has to be of a certain size in order to be statistically significant though. To test if a difference in results between two sub-groups within a sample is statistically significant one, at the 95% confidence interval, the differences between the two results must be greater than the values provided in the table below. Again, strictly speaking the sampling tolerances shown here apply only to random samples with an equivalent design effect. In practice, good quality quota sampling has been found to be as accurate.

Differences required for significance at or near these percentages			
	10% or 90%	30% or 70%	50%
Size of sample on which survey result is based	±	±	±
100 and 100	8	13	14
100 and 200	7	11	12
100 and 300	7	10	11
100 and 400	7	10	11
100 and 500	7	10	11
200 and 200	7	10	11
200 and 300	5	8	9
200 and 400	5	8	9
200 and 500	5	8	8
300 and 300	5	7	8
300 and 400	5	7	8
300 and 500	4	7	7
400 and 400	4	6	7
400 and 500	4	6	7
500 and 500	4	6	6
1603 and 1609 (2013 and 2012 surveys)	2	3	4
1603 and 1563 (2013 and 2011 surveys)	2	3	4
1609 and 1563 (2012 and 2011 surveys)	2	3	4

Appendix B: Topline findings

General Dental Council Patient and Public Survey 2013
Topline Results

- This document details results from an Ipsos MORI omnibus survey conducted with 1603 adults aged 15 and over in the United Kingdom between 27 September and 7 October 2013. Booster interviews were carried out to ensure at least 100 interviews each in Wales and Northern Ireland. All respondents were interviewed face-to-face, in their homes.
- A similar survey also took place between 31 August and 16 September 2012, and between 8 April and 17 April 2011. Data from questions that were also asked in those surveys are included in this document.
- Results are based on all respondents unless otherwise stated (1603 in 2013, 1609 in 2012 and 1563 in 2011).
- The 2013 and 2012 data is weighted to the known population profile for the United Kingdom.
- Respondents were asked to choose one answer code for each question unless otherwise stated.
- Where percentages do not sum to 100, this may be due to respondents being able to give multiple responses to a question or computer rounding. An asterisk (*) indicates a percentage of less than 0.5% but greater than zero.

Use of Dentists and Dental Care Professionals

A1 **When was the last time you went to the dentist?**

	2013 %	2012 %	2011 %
In the last 6 months	51	50	53
In the last 7-12 months	15	16	12
In the last 1-2 years	10	10	10
More than 2 years' ago	11	10	15
I used to go to the dentist but I don't any more	9	8	7
I have never been to the dentist	4	7	3
Don't know	*	1	N/A

A2 **On average, how often do you go to the dentist?**
Base: People who go to the dentist: 2013 (1376); 2012 (1320)

	2013 %	2012 %
Once every six months	54	52
Once a year	24	27
Once every two years	9	8
Less than once every two years	13	12
Don't know	*	*

A3 **And how long have you been with your current dentist or dental practice?**
Base: People who go to the dentist: 2013 (1376); 2012 (1320)

	2013 %	2012 %
One year or less	11	14
Over one year, up to two years	9	13
Over two years, up to five years	20	22
Over five years, up to 10 years	19	18
Over 10 years, up to 15 years	12	11
Over 15 years, up to 20 years	9	7
Over 20 years	18	14
Don't know	2	1

A4 **As you're probably aware, dental care is available both through the NHS and privately. Sometimes during one visit to the dentist, you may even have a combination of NHS and private treatment. Thinking about the last time you visited your dentist or dental practice, which of these options best describes the type of care you think you received?**
Base: People who go to the dentist at least once every two years: 2013 (1188); 2012 (1145)

	2013 %	2012 %
NHS dental care that I paid for	48	45
NHS dental care that was free	24	31
Private dental care only in the UK	20	18
NHS dental care and additional private dental care in the UK	6	5
I had treatment abroad	1	1
I'm not sure what type of care I received	1	*

A5 **The term 'dental care professional' covers a range of different professions within dental care. Dental care professionals are: dental nurses, dental technicians, clinical dental technicians, dental hygienists, dental therapists and orthodontic therapists. Have you ever had an appointment with a dental care professional other than a dentist? By this we mean an appointment where <u>the dentist was not present</u>.**
Base: People who have been to a dentist at some point: 2013 (1524); 2012 (1464)

	2013 %	2012 %
Yes	37	27
No	63	73
Don't know	*	*

A6 **You said you have had an appointment with a dental care professional other than a dentist. Which dental care professional or professionals did you see? Please select all that apply.**
Multi-code question except for 'Don't know/can't remember' answer code.
Base: People who have had an appointment with a dental care professional other than a dentist: 2013 (519); 2012 (340)

	2013 %	2012 %
Dental hygienist	77	72
Orthodontic therapist	14	15
Dental nurse	8	9
Dental technician	7	8
Clinical dental technician	2	3
Dental therapist	1	1
Other	1	1
Don't know/can't remember	*	1

A7 **You said you have had an appointment with** <INSERT NAME OF DENTAL CARE PROFESSIONALS SELECTED AT A6>.
When was the last time you had an appointment with <INSERT NAME OF DENTAL CARE PROFESSIONALS SELECTED AT A6>?
Base: People who have had an appointment with a dental care professional other than a dentist:

			In the last 6 months	In the last 7-12 months	In the last 1-2 years	More than 2 years' ago	Don't know
			%	%	%	%	%
Dental nurse	2013	*(44)*	44	15	8	30	2
	2012	*(30)*	45	16	7	28	5
Dental technician	2013	*(37)*	27	23	11	39	0
	2012	*(24)*	19	30	7	44	0
Clinical dental technician	2013	*(11)*	21	11	7	61	0
	2012	*(5)*	0	46	17	37	0
Dental hygienist	2013	*(386)*	39	19	13	30	0
	2012	*(239)*	38	24	14	23	0
Dental therapist	2013	*(6)*	12	28	19	41	0
	2012	*(3)*	67	33	0	0	0
Orthodontic therapist	2013	*(78)*	20	9	4	67	0
	2012	*(54)*	11	6	11	72	0
Other	2013	*(9)*	41	13	0	47	0

A8 **On average, how often do you see** <INSERT NAME OF DENTAL CARE PROFESSIONALS SELECTED AT A6>?

Base: People who have had an appointment with a dental care professional other than a dentist:

			Once every six months	Once a year	Once every two years	Less than once every two years	Don't know
			%	%	%	%	%
Dental nurse	2013	*(44)*	20	46	6	27	2
	2012	*(30)*	36	29	1	28	5
Dental technician	2013	*(37)*	19	14	13	53	0
	2012	*(24)*	0	22	17	58	3
Clinical dental technician	2013	*(11)*	7	16	0	76	0
	2012	*(5)*	24	0	39	37	0
Dental hygienist	2013	*(386)*	38	18	11	32	*
	2012	*(239)*	30	30	9	31	*
Dental therapist	2013	*(6)*	12	0	0	88	0
	2012	*(3)*	67	33	0	0	0
Orthodontic therapist	2013	*(78)*	13	11	0	76	0
	2012	*(54)*	12	1	3	85	0
Other	2013	*(9)*	41	0	0	59	0

Satisfaction with Dental Care

Q1 **Is there a particular dental professional you usually prefer to see or speak to?**

Base: People who go to the dentist at least once every two years: (1188)

	%
Yes	51
No	42
There is usually only one dentist or dental care professional in my surgery	7

Q2 **Now thinking about <u>your own experience</u>, how satisfied or otherwise are you with your dental care or treatment?**

Base: People who go to the dentist at least once a year: (1063)

	%
Very satisfied	61
Fairly satisfied	35
Fairly dissatisfied	2
Very dissatisfied	1
Don't know	*

Q3 **Which of the following, if any, best describe why you feel satisfied with your dental care or treatment? Please select as many or as few as apply.**
Multi-code question
Base: People who are satisfied with their dental care or treatment: (1018)

	%
The dental professional behaved in a professional way	80
The dental professional provided good quality treatment	73
I received a clear explanation about my dental treatment	58
The dental professional had good communication skills	57
The dental professional knew my dental history	56
I received good follow up treatment	41
The cost of my dental treatment was reasonable	37
I received clear information about the cost of my treatment	37
Other	1
None of these	*
Don't Know	1

Q4 **Which of the following, if any, best describe why you feel dissatisfied with your dental care or treatment? Please select as many or as few as apply.**
Multi-code question
Base: People who are dissatisfied with their dental care or treatment: (43)

	%
The dental professional provided poor quality treatment	50
The cost of my dental treatment was unreasonable	27
The dental professional had poor communication skills	23
The dental professional did not know my dental history	12
I did not receive a clear explanation about my dental treatment	9
The dental professional behaved in an unprofessional way	8
I received poor follow up treatment	7
I did not receive clear information about the cost of my treatment	6
Other	15
None of these	0
Don't know	0

Regulation of Dental Professionals

The following questions will be asked about your views on the regulation of different types of services. By 'regulation' we mean where there is a set of rules that govern behaviour, actions and conduct, and where action may be taken if these rules aren't met.

Q5 **Now please think about services generally and not just dental care or healthcare services. How confident, if at all, are you that regulation of services in general works effectively?**

	2013 %	2012 %
Very confident	14	13
Fairly confident	56	58
Not very confident	21	18
Not at all confident	3	5
Don't know	6	7

In 2012, the question was worded: 'How confident, if at all, are you that regulation in general works effectively'.

Q6 **Now thinking about healthcare, how confident, if at all, are you that regulation of this works effectively?**

	2013 %	2012 %
Very confident	14	14
Fairly confident	57	58
Not very confident	20	17
Not at all confident	4	6
Don't know	5	6

In 2012, the question was worded: 'How confident, if at all, are you that healthcare in general works effectively'.

Q7 **Which of the following professions, if any, do you think are regulated? Please select all that apply.**
Multi-code question

	2013 %	2011 %
Doctors	90	76
Dentists	86	69
Nurses	78	63
Pharmacists	73	64
Health Professionals (e.g. Physiotherapists, Occupational Therapists, Radiographers etc.)	72	49
Opticians	68	57
Osteopaths	43	N/A
Chiropractors	42	39
Beauty Therapists	14	N/A
None	1	1
Don't Know	5	15

Q8 **How important or unimportant is it to you that dentists and dental care professionals are regulated? Please state on a scale of 1 to 10 with 1 indicating not important and 10 very important.**

	2013 %	2011 %
1 – not important	1	2
2	*	0
3	1	*
4	1	1
5	5	4
6	3	2
7	5	3
8	9	7
9	9	8
10 – very important	66	73

Q9 **Which of the following, if any, do you think are responsible for regulating dentistry?**
Multi-code question except for 'None of these' and 'Don't know' answer codes.

	%
British Dental Association/BDA	44
The NHS	29
General Dental Council/GDC	25
General Medical Council (GMC)	13
Dentist/Dental Surgery	8
Government/devolved government	8
Care Quality Commission (CQC)/Healthcare Improvement Scotland (HIS)/Healthcare Inspectorate Wales (HIW)/Regulation and Quality Improvement Authority (RQIA) (Northern Ireland)	8
Ombudsman	3
Local Council	2
HealthWatch/other patient and consumer watchdog/champion	2
None of these, but I don't think any organisation is	2
None of these, but I think there is an organisation which is	6
Don't know	12

Q10 **Which of the following best describes how aware you were of the General Dental Council before this survey?**

	2013 %	2012 %	2011 %
I had definitely heard of the General Dental Council before	15	20	10
I think I had heard of the General Dental Council before	27	21	15
I had not heard of the General Dental Council before	58	57	70
Not sure	1	2	5

In 2012 and 2011, the answer codes were worded: 'I have definitely heard of the General Dental Council before', 'I think I have heard of the General Dental Council before', and 'I have not heard of the General Dental Council before'.

Q11 **How confident, if at all, are you that the General Dental Council is regulating dentists and dental care professionals effectively?**
Base: People who have heard of the General Dental Council before: 2013 (644); 2012 (602)

	2013 %	2012 %
Very confident	15	12
Fairly confident	62	66
Not very confident	16	13
Not at all confident	1	3
Don't know	5	6

Q12 **And overall how confident, if at all, are you that dentists and dental care professionals follow the General Dental Council rules?**
Base: People who have heard of the General Dental Council before: 2013 (644); 2012 (602)

	2013 %	2012 %
Very confident	17	15
Fairly confident	63	65
Not very confident	13	11
Not at all confident	2	2
Don't know	5	6

Q13 **The General Dental Council protects patients by regulating dental professionals in the UK. So, all dentists, dental nurses, dental technicians, clinical dental technicians, dental hygienists, dental therapists and orthodontic therapists must be registered with the General Dental Council to work here. For each of the statements below please state whether you think it is true or false:**

		True	False	Don't know
		%	%	%
Only qualified dentists registered by the General Dental Council are allowed to work as dentists in the UK.	2013	80	12	9
	2011	67	13	19
There is a publicly available General Dental Council register that allows me to check whether a dentist or dental care professional is allowed to provide dental care.	2013	69	14	17
	2011	62	11	27
There are publicly available General Dental Council lists of dentists who are specialists in particular types of dentistry.		68	15	17
Dentists and dental care professionals are tested to ensure that they are fluent in written and spoken English before they can practise.		53	35	13
Dentists and dental care professionals who have qualified overseas and practise in the UK receive training about how the UK dental system works.		62	24	14
Dentists and dental care professionals who have qualified overseas and practise in the UK receive training about how dental patients expect to be treated in the UK.		52	35	14

In 2011 the introduction to this question was worded: 'The General Dental Council (the GDC) is the regulator for dental professionals. By regulation we mean protecting the patient by setting standards for dentists or dental professionals and taking action where the standards are not met.'

In 2011, the first statement was worded: Only qualified dentists registered by the General Dental Council can work as dentists in the UK.

In 2011, the first statement was worded: 'There is a publicly available General Dental Council register that allows me to check whether a dentist or dental care professional is legally qualified to provide dental care.'

Q14 **I am going to describe some situations where poor care or serious wrongdoing might occur. For each situation, please could you tell me how confident, if at all, you would be that appropriate action would be taken by a regulator?**

	Very confident	Fairly confident	Not very confident	Not at all confident	Don't know
	%	%	%	%	%
Patients being repeatedly overcharged for dental treatment at their dental practice.	12	40	33	6	8
Residents in a care home receiving poor dental care.	10	38	34	6	12
Disabled patients receiving poor dental care.	11	40	31	7	11

Q15 **During the last year, have you been aware or not of the General Dental Council taking disciplinary action against a dental professional because they do not meet the standards required or are not fit to practise?**
Base: People who have heard of the General Dental Council before: (644)

	%
Yes, definitely	13
Yes, maybe	16
No	70
Don't know	1

Q16 **Have you ever checked whether or not the dental professionals you have used have had any disciplinary action taken against them?**

	%
Yes	1
No	99

Q17 **How did you check this?**
Multi-code question
Base: People who have checked whether the dental professionals they have used have had any disciplinary action taken against them: (22)

	N
Asked friends and/or family	10
Asked another dental professional not at the same dental practice	2
Consulted the General Dental Council	2
Reviewed media coverage	2
Consulted the Care Quality Commission	1
Asked staff at the dental practice	1
Consulted the Health Service Ombudsman	0
Other	5
Don't know/can't remember	0

Q18 **If you were to check whether or not the dental professionals you have used have had any disciplinary action taken against them, how would you do this?**
Multi-code question
Base: People who have not checked whether the dental professionals they have used have had any disciplinary action taken against them: (1574)

	%
Consult the General Dental Council	34
Ask friends and/or family	18
Ask staff at the dental practice	11
Ask another dental professional not at the same dental practice	5
Review media coverage	4
Consult the Health Service Ombudsman	4
Consult the Care Quality Commission	2
Other	17
None of these	2
Don't know/can't remember	16

Complaints

Q19 **Have you ever complained about a dental professional?**
Base: People who have been to a dentist at some point: 2013 (1524); 2012 (1464)

	2013 %	2012 %
Yes	4	3
No	96	95
Don't know	*	1
Prefer not to say	0	1

Q20 **Have you ever *considered* complaining about a dental professional?**
Base: People who have not, don't know or prefer not to say if they have complained about a dental professional: 2013 (1467); 2012 (1422)

	2013 %	2012 %
Yes	8	5
No	92	93
Don't know	*	1
Prefer not to say	0	1

Q21 **Thinking about the most recent time you complained or considered complaining, who did you complain or consider complaining to?**
Multi-code question except for 'Don't know' answer code.
Base: People who have complained or considered complaining about a dental professional: 2013 (165); 2012 (116)

	2013 %	2012 %
The practice where the treatment was carried out	41	37
The General Dental Council	9	10
The NHS	7	3
The Dental Complaints Service	4	7
A Health Ombudsman	2	4
Trading Standards	2	1
The Care Quality Commission	1	1
Other	9	1
I wasn't sure who to complain to	27	32
Don't know	2	8

In 2012, the answer code 'The NHS' was worded 'A primary care trust/Health Board'.

Issues Arising from the Francis Report

Q22 **How likely or unlikely do you think a dental professional would be to provide an explanation to a patient when something has gone wrong in their care or treatment?**

	%
Very likely	19
Fairly likely	50
Not very likely	21
Not at all likely	5
Don't know	5

Q23 **What do you think should happen to dental professionals if they do not provide an explanation to the patient when something has gone wrong in their care or treatment?**

	%
Nothing	6
They should be disciplined by the professional regulator	82
Something else	8
Don't know	4
No answer	*

Q24 **Health and dental regulators, and the NHS should share information between each other so that they can investigate poor treatment. To what extent do you think this happens?**

	%
To a great extent	14
To some extent	50
Hardly at all	25
Not at all	6
Don't know	6

Compliance with General Dental Council Standards

Q25 **Thinking about the last time you visited your dentist or dental care professional, to what extent do you agree or disagree that the following occurred during your visit?**

Base: People who go to the dentist: (1376)

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	Not applic-able
	%	%	%	%	%	%	%
The dental professional discussed the options for treatment thoroughly with me.	48	30	12	5	3	1	*
The dental professional gave me enough information about the treatment options.	47	31	13	4	3	1	*
The dental professional allowed me enough time to make a decision.	46	31	14	4	3	1	*
There was a simple price list on display.	24	17	21	14	21	2	*
I felt clear about what treatment the dental professional could provide through the NHS and what treatment I would have to receive privately.	38	28	19	6	7	1	*
Information was displayed stating that the dental professionals were regulated by the General Dental Council.	15	19	36	12	13	4	*

Choosing a Dental Practice

Q26 **What were the most important factors in selecting your current dental practice?**
Probe: **What else?**
Multi-code question, up to three answer codes.
Base: People who go to the dentist: (1376)

	%
RECOMMENDATION/EXPERIENCE	52
Previous/personal experience	18
Reputation	17
Professional recommendation/advice	6
Advice/recommendation from friends/family	19
LOCATION/QUALITY	65
Location/close to where I live	44
Ease/speed of access/convenience	4
Quality of the service	13
Speciality/expertise/facilities	2
Attitude of staff	4
Availability	7
Cost/value for money	6
The practice looked attractive/smart	2
NOT MUCH CHOICE	5
I didn't like any others	*
It was the only choice I had/I had no other choice	3
I didn't really think about it	2
Other	1
OTHER	22
The practice accepted new patients	6
The practice accepted NHS patients	14
I have always used this dentist	6
Don't know	1

Q27 **The government is discussing plans to introduce a star rating system for hospitals and doctors (for example, rating hospitals from one to five stars where five stars is excellent and one star is very poor). How useful, if at all, would you find a system like this when choosing where to go for your dental care?**

	%
Very useful	33
Fairly useful	40
Not very useful	15
Not at all useful	11
Don't know	2

Cosmetic Dentistry

I am now going to ask you some questions about cosmetic dentistry. Cosmetic dentistry treatment includes teeth whitening, making teeth straight, veneers, implants, teeth jewellery etc.

Q28 **To what extent do you agree or disagree with the following statements?**

	Strongly agree %	Tend to agree %	Neither agree nor disagree %	Tend to dis- agree %	Strongly dis-agree %	Don't know %
Cosmetic dentistry should only be carried out by dental professionals who are regulated.	62	25	9	1	*	2
There should be clear and accessible information available to the public about who is qualified to carry out cosmetic dentistry treatment.	63	26	8	1	*	2

Specialists

Q29 **Please read the following pair of statements and decide, on a scale of 1 to 5, which comes closest to your own opinion. A score of 1 means you agree much more with statement A while a score of 5 means you agree much more with statement B.**

A) If I needed to see a dental specialist, such as an orthodontist, I would prefer my dentist to refer me to one.
B) If I needed to see a dental specialist, such as an orthodontist, I would prefer to find one myself.

	%
1 – Agree much more with statement A	71
2	9
3 – Agree equally with statements A and B	11
4	2
5 – Agree much more with statement B	4
Don't know	2

Dentistry as a Business

Q30 **To what extent do you agree or disagree that dental professionals put their own profit before the needs of their patients?**

	%
Strongly agree	10
Tend to agree	29
Neither agree nor disagree	37
Tend to disagree	17
Strongly disagree	4
Don't know	3

Re-contacting Respondents for Future Research

Q31 **Both Ipsos MORI and the General Dental Council may wish to carry out some follow up research about this subject within the next 12 months. Would you be willing for us, Ipsos MORI, and the General Dental Council to securely keep hold of your contact details for this period so that either organisation can invite you to take part in the research? Please be assured that your responses to today's survey will remain confidential to Ipsos MORI, and that both organisations would securely delete any re-contact details you agree to provide here after 12 months, unless you agree otherwise during the follow up research.**

	%
Yes	30
No	70

Demographics

Gender

	%
Male	49
Female	51

Age

	%
15-24	16
25-34	17
35-44	17
45-54	17
55-64	15
65+	19

Social grade

	%
A	3
B	23
C1	28
C2	22
D	16
E	8

Marital status

	%
Married/living as	56
Single	27
Widowed/divorced/separated	16

Working

	%
Working	55
Not working	45

Occupation

	%
Full-time	39
Part-time	11
Self-employed	5
Not working – housewife	6
Still in education	7
Unemployed	5
Retired	22
Other	5

Children in household

	%
Yes	31
No	69

Children's ages
Multi-code question

	%
Aged 0-3	11
Aged 4-5	7
Aged 6-9	11
Aged 10-15	15
None aged under 16	69

Location

	%
England	82
London	12
North	23
Midlands	20
South	27
Northern Ireland	3
Scotland	8
Wales	6

Ethnicity

	%
White	89
Non-white	11

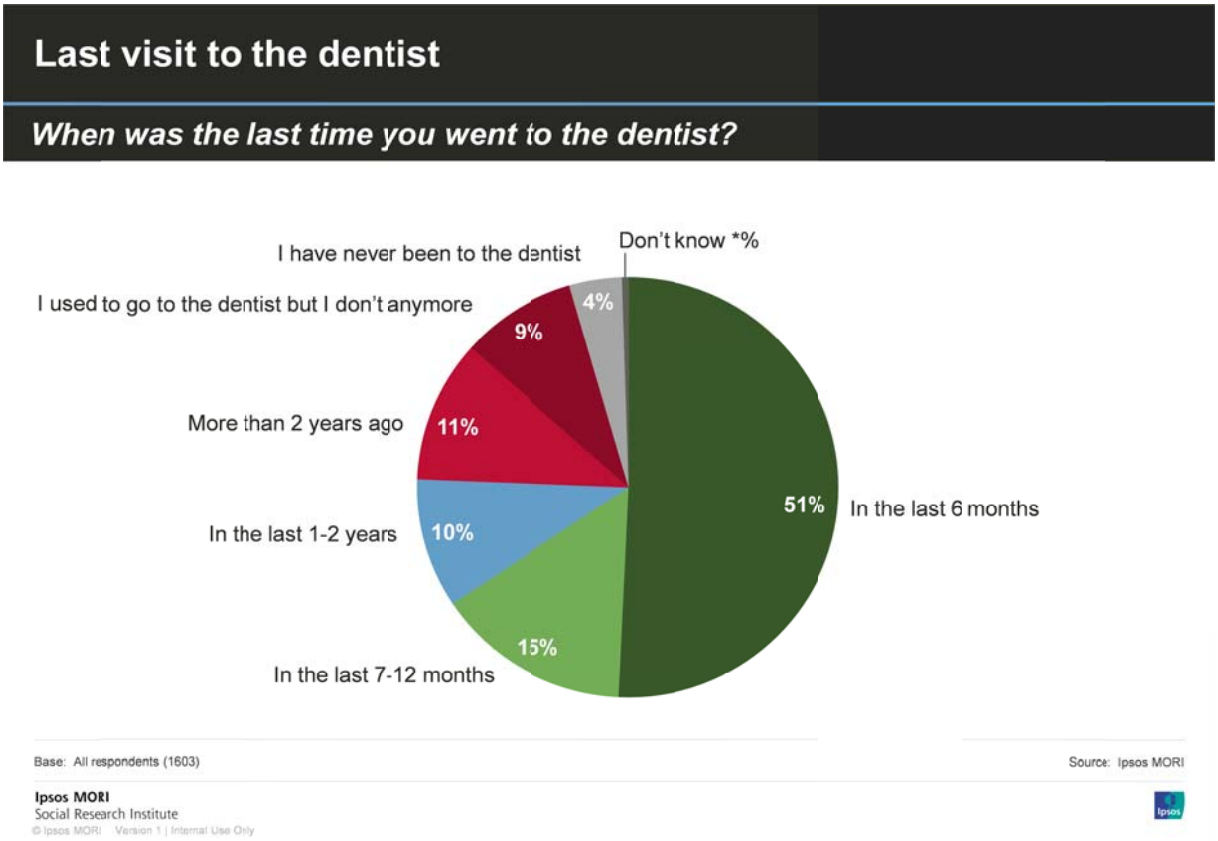
Access to internet
Multi-code question

	%
Home	82
Work	32
Total	83
None	17

Appendix C: Public and patient use of dental professionals

Last visit to the dentist

Half (51%) of respondents have been to the dentist in the last 6 months.

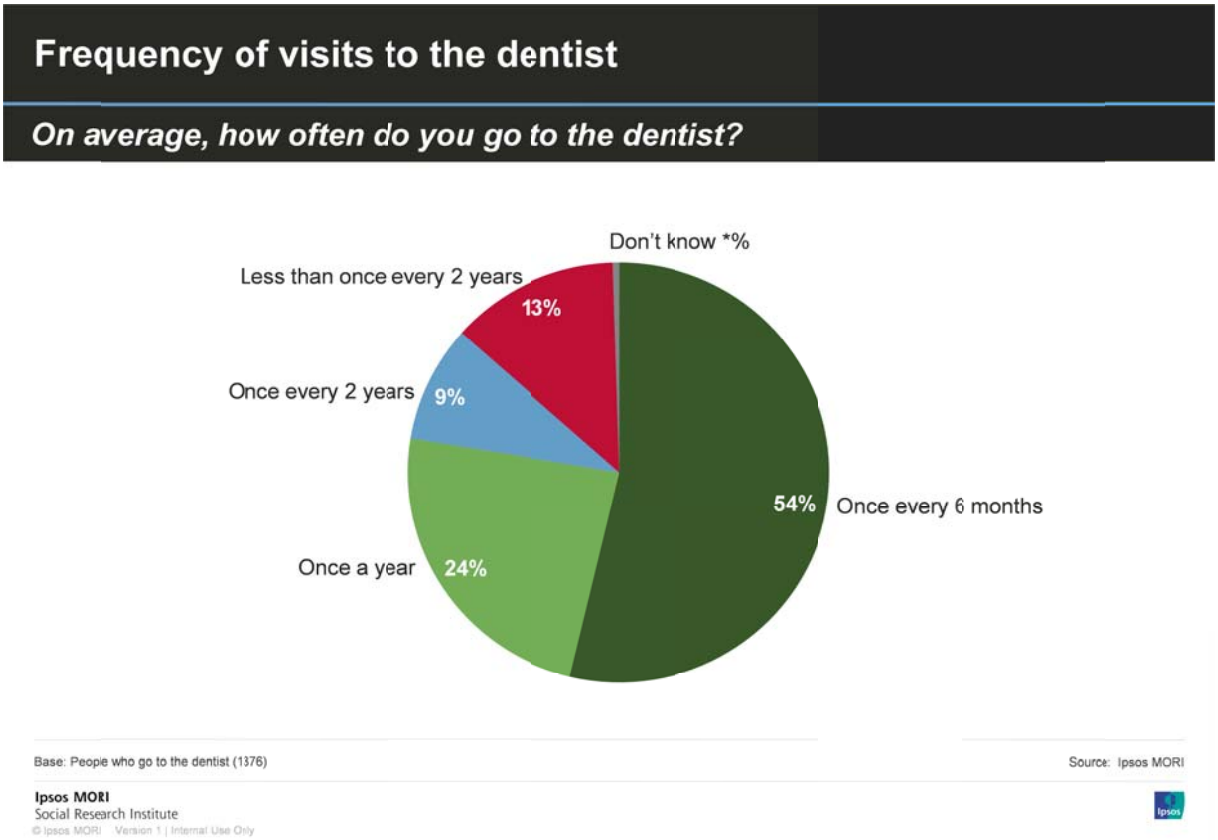


Those most likely to have visited in the last 6 months include:

- Women (55% vs. 46% of men)
- Middle aged or older people (56% among those aged 35 and older vs. 41% aged 15-34)
- People in social grade B (62%) compared to other social grades (48% among social grade A, 51% among C1C2, 41% among DE)
- Married or cohabiting people (57% vs. 42% of single people)
- White people (54% vs. 31% of people of ethnic minorities).

Frequency of visits to the dentist

Just over half (54%) of respondents visit the dentist at least once every six months.

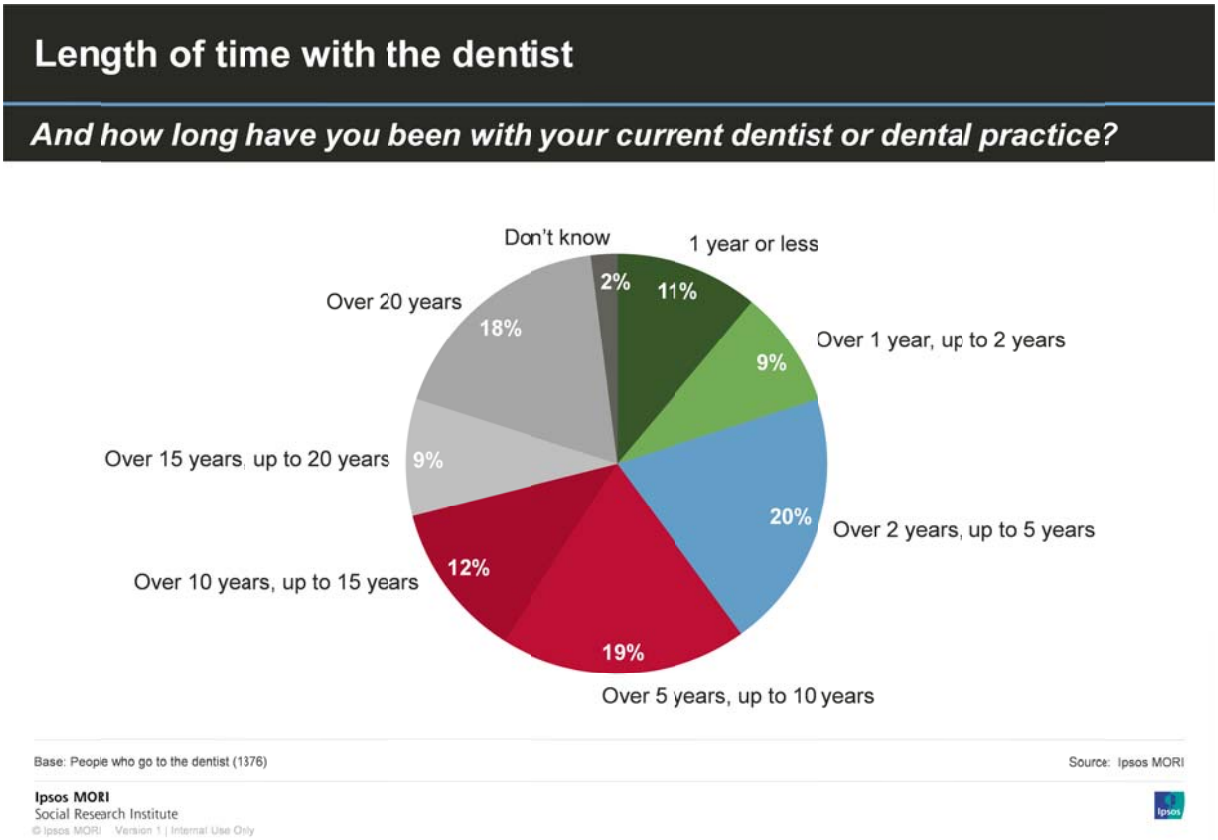


People visiting at least once every six months are most likely to be:

- Women (59% vs. 48% of men)
- Middle aged or older people (58% among those aged 35 and older vs. 45% aged 15-34)
- People in higher social grades (59% among social grades AB vs. 51% in social grade C1C2DE)
- Married or cohabiting people (58% vs. 46% of single people)
- White people (55% vs. 38% of people of ethnic minorities)

Length of time with current dentist

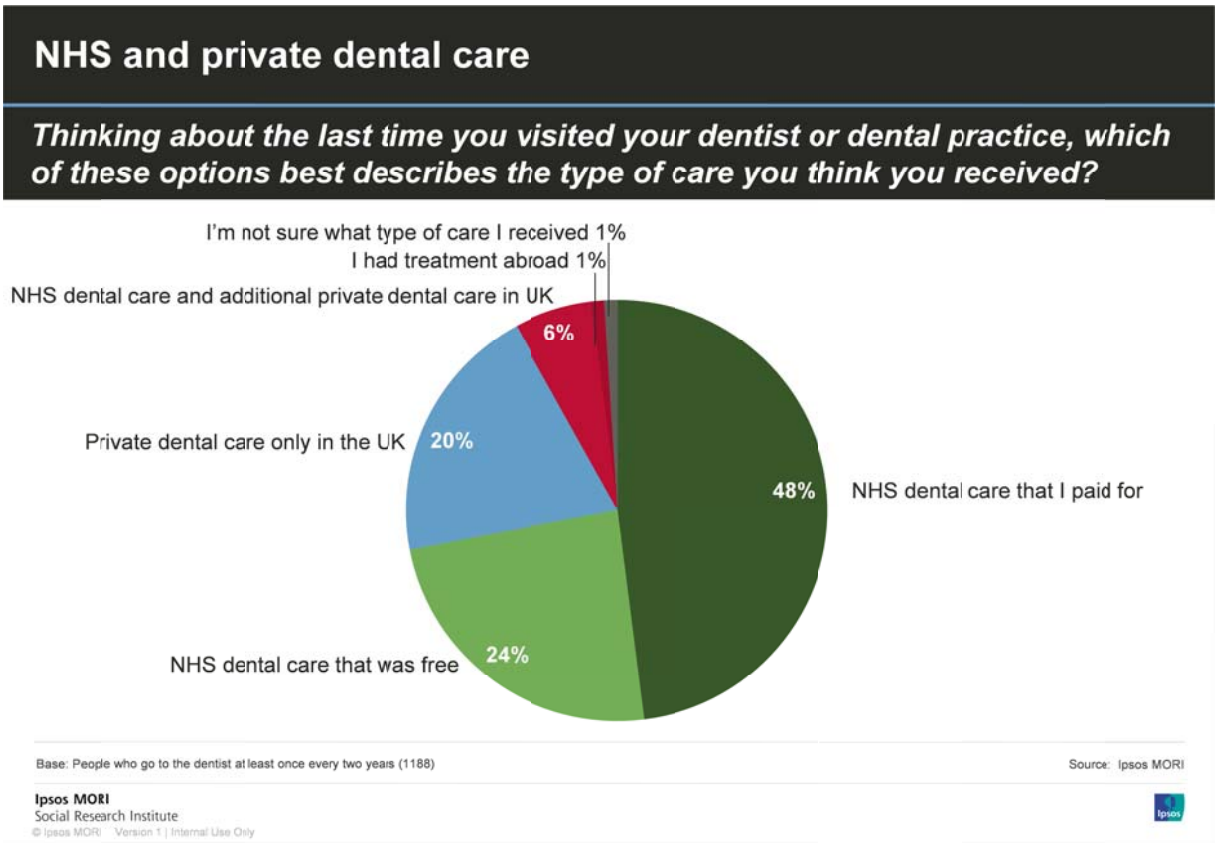
Most (58%) respondents have been with their current dentist for at least five years.



Older people tend to have been with their current dentist for the longest (22% aged 45-64, and 37% of those aged 65+ have been with their current dentist for more than 20 years compared with 9% among those aged 35-44). Minority ethnic people are significantly more likely than white people to have been with their current dentist for one year or less (19% vs. 11%).

NHS and private care

Three quarters (72%) of respondents had at least some NHS treatment at their last appointment. Private dental care was accessed by one in five (20%).

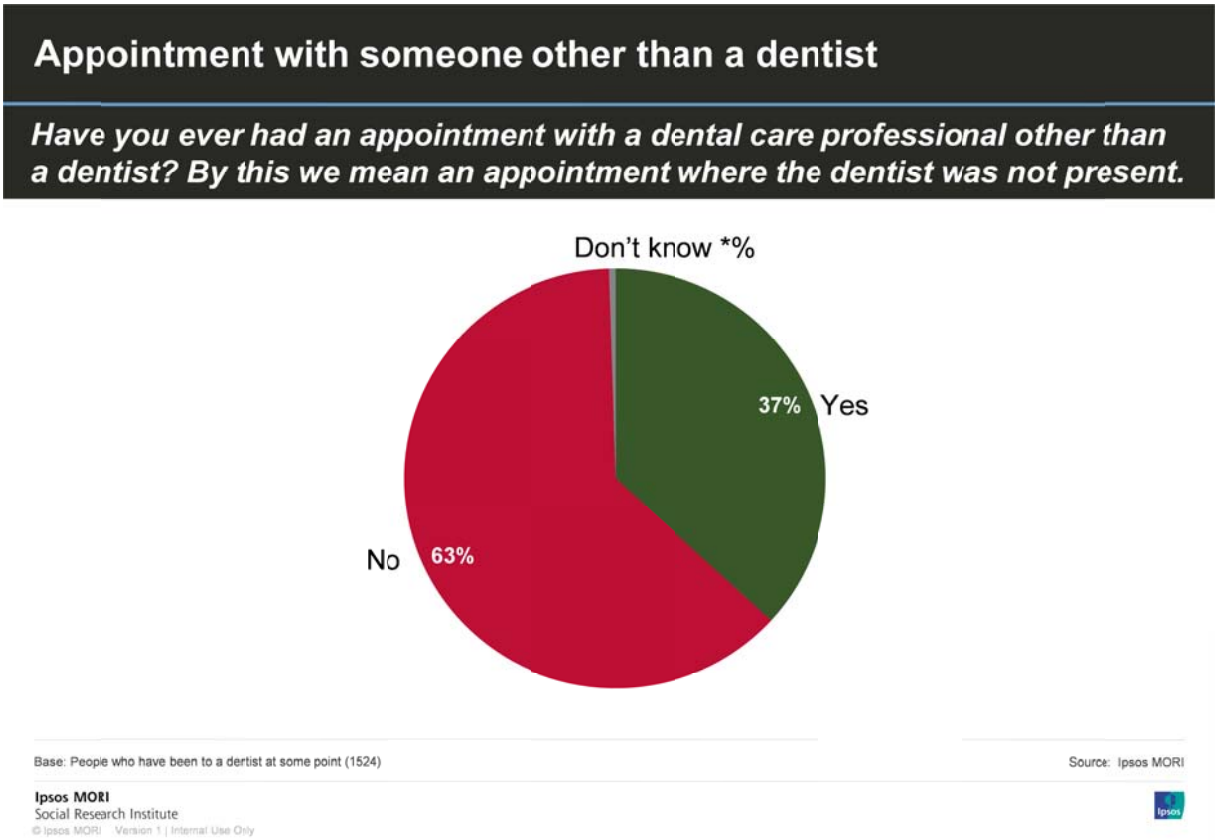


People who had free NHS care tended to be young (46% aged 15-24 vs. e.g. 15% aged 45-54) and from lower social grades (e.g. 12% in social grade B vs. 66% in social grade E).

People who accessed private dental care tended to be aged 45 and above (28%) and in higher social grades (38% social grade A; 24% social grade BC1).

Appointment with someone other than a dentist

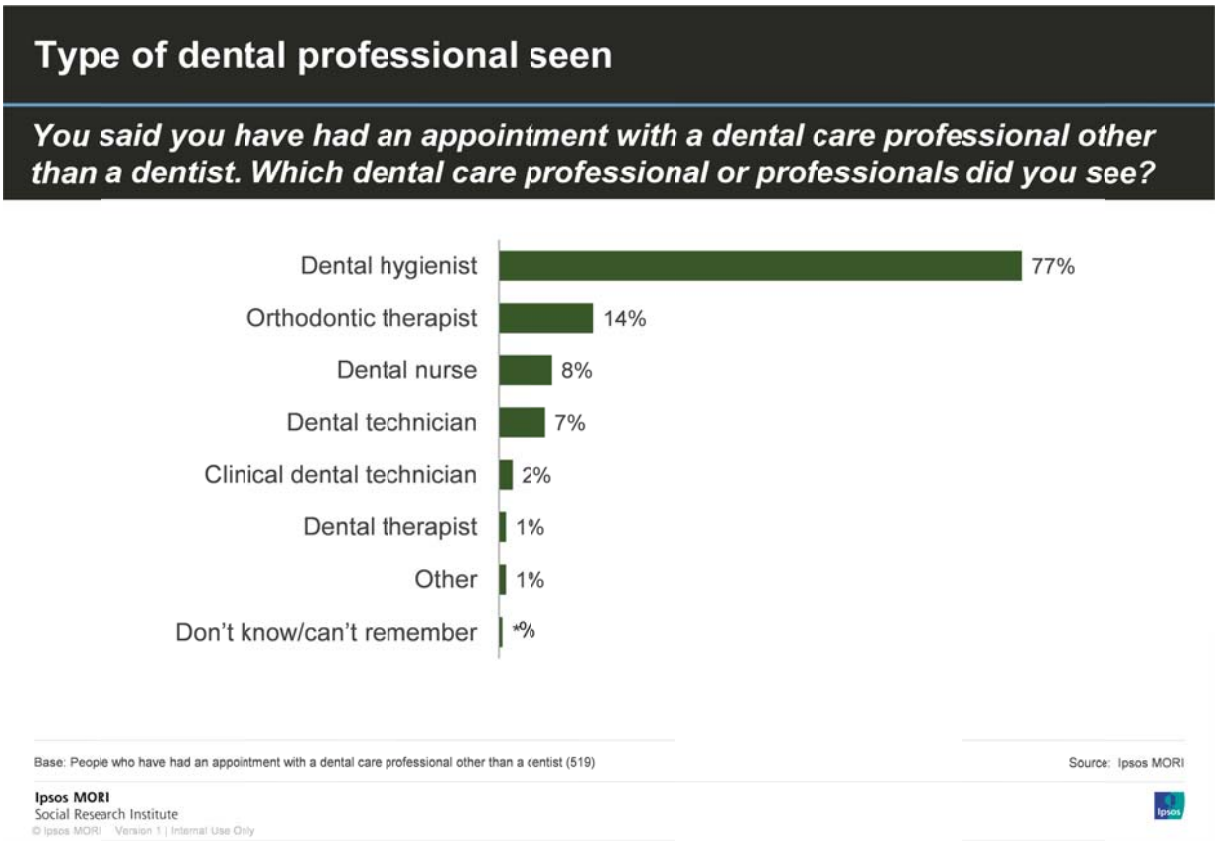
Most (63%) people have only ever seen a dentist.



People in higher social grades are most likely to have seen someone other than a dentist (e.g. 69% in social grade A, 44% in grades BC1 and 26% C2DE). White people are also more likely than people of ethnic minorities to have done so (38% vs. 21%).

Professionals seen other than a dentist

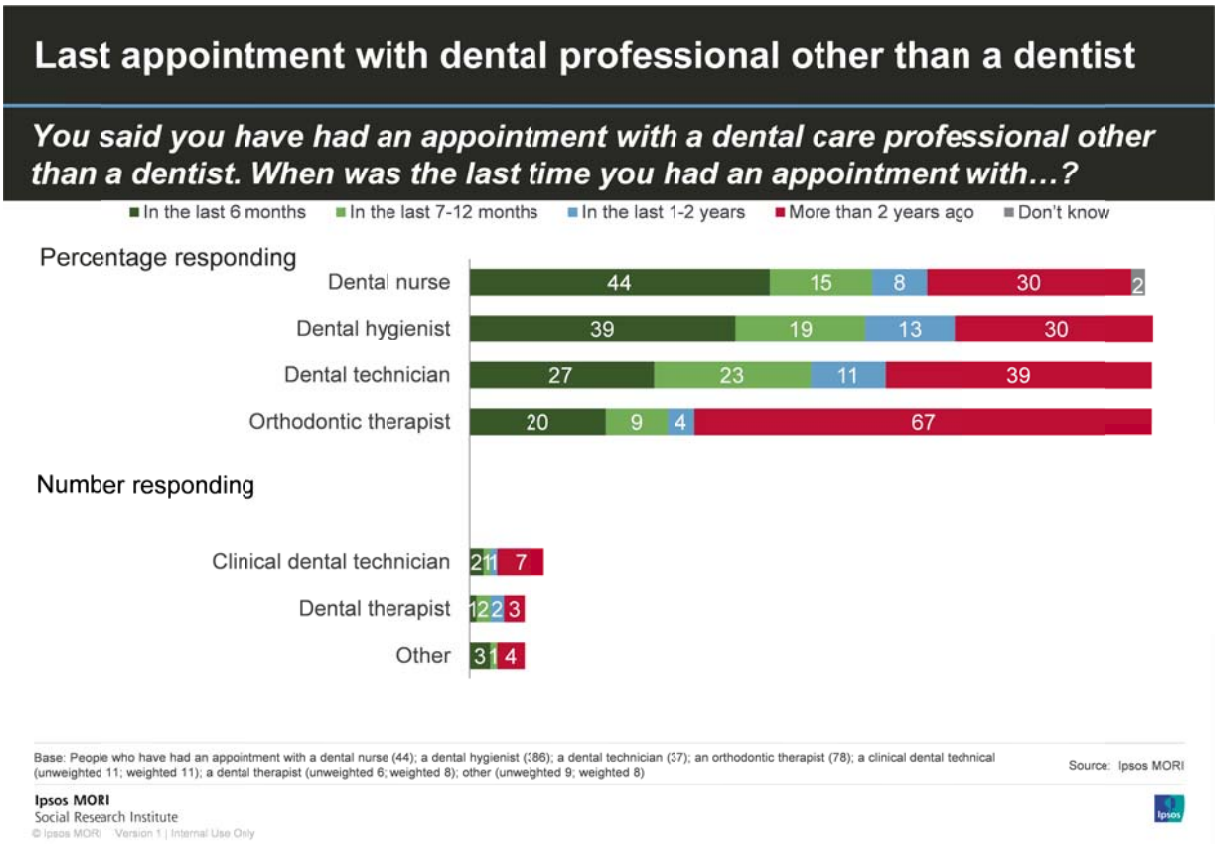
Of those who had seen a professional other than a dentist, the great majority (77%) had seen a dental hygienist.



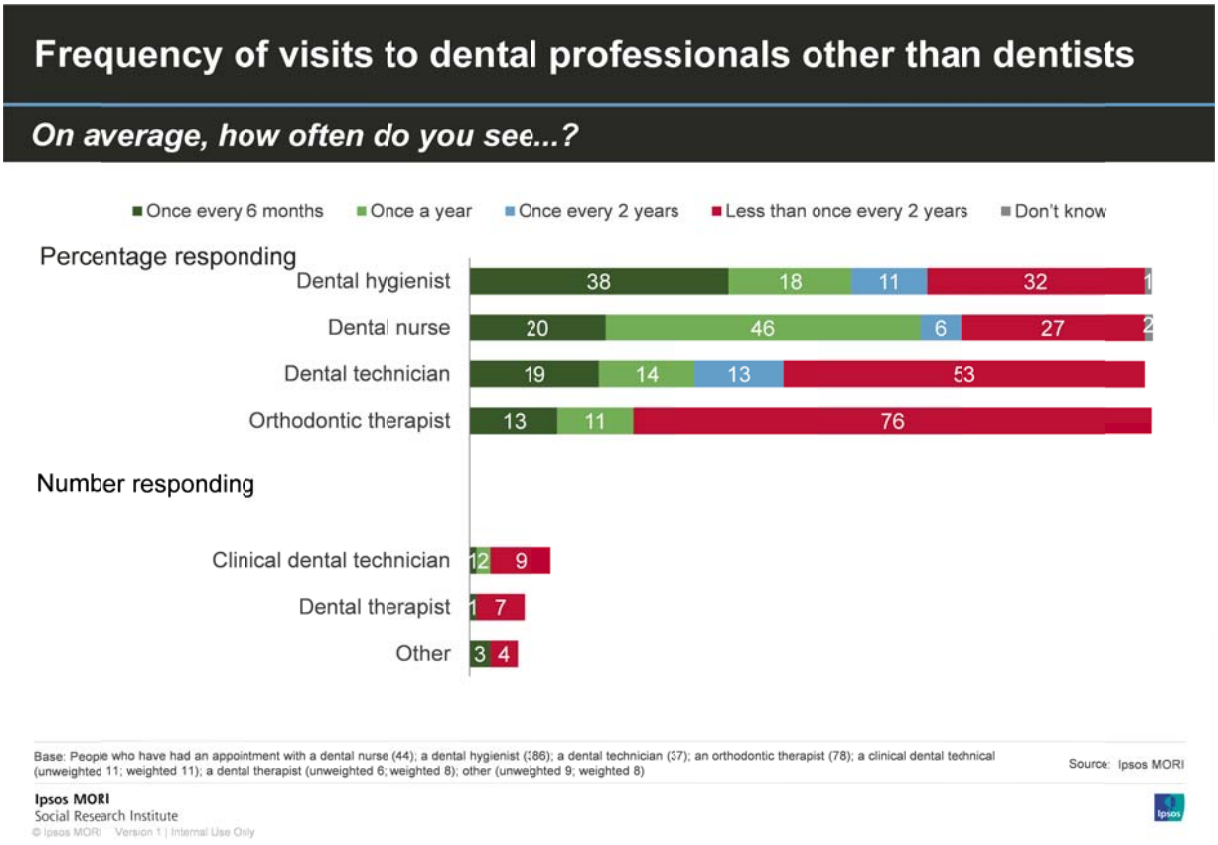
The youngest age group (aged 15-24) were by far the most likely to have seen an orthodontic therapist (52% vs. 14% overall).

Time and frequency of last appointment with someone other than a dentist

Appointments with the orthodontic therapist tend to have been at least 2 years ago. Those with dental hygienists tend to have been within the last year. Please note that there are some small base sizes here, so results should be treated with caution.



Visits to an orthodontic therapist tend to be infrequent. Regarding dental hygienists, people tend to visit once a year or more. Again please note that there are some small base sizes here, so results should be treated with caution.



Appendix D: Profile of qualitative interviews

	Age	Gender	Social Grade	Ethnicity	Last visit to dentist	Length of time at current dental practice	Private dental treatment	Awareness of General Dental Council	Location
Participant 1	65	Female	B	White British	In the last 6 months	Over 15 years, up to 20 years	Private dental care only in the UK	Think had heard of GDC	Scotland
Participant 2	59	Male	B	White British	In the last 1-2 years	Over 10 years, up to 15 years	NHS dental care that was free	Had definitely heard of GDC	England
Participant 3	46	Male	C1	White British	In the last 6 months	One year or less	NHS dental care that was free	Think had heard of GDC	England
Participant 4	56	Male	A	White British	In the last 7-12 months	Over 20 years	Private dental care only in the UK	Had not heard of GDC	Wales
Participant 5	33	Female	B	Asian Other	Used to go to the dentist but not any more	Over two years, up to five years	Private dental care only in the UK	Had not heard of GDC	England
Participant 6	30	Male	D	African	In the last 1-2 years	Over 20 years	NHS dental care that was free	Had not heard of GDC	England
Participant 7	23	Male	E	Mixed (White and Asian)	In the last 7-12 months	One year or less	NHS dental care that was free	Think had heard of GDC	England
Participant 8	18	Female	C1	White British	In the last 6 months	Over two years, up to five years	NHS dental care that was free	Think had heard of GDC	Northern Ireland
Participant 9	35	Female	E	White British	In the last 7-12 months	One year or less	NHS dental care that was free	Had not heard of GDC	Wales
Participant 10	66	Male	C2	White British	Used to go to the dentist but not any more	One year or less	NHS dental care that was free	Had definitely heard of GDC	Scotland
Participant 11	51	Female	C2	White British	More than 2 years' ago	One year or less	NHS dental care that was free	Had definitely heard of GDC	England

Appendix E: Discussion guide for qualitative focus groups

GDC Patients and Public Annual Survey: Follow up research
Discussion Guide (09/12/13)

Objectives
Follow up from the previous research and explore issues in greater depth. In particular we wish to explore:

- General attitudes towards/ around dentistry.
- Explore what quality means to patients at different stages of the patient journey.
- Explore the "trigger points" – what makes people dissatisfied and what makes them choose to exit, or stay loyal and voice their complaints on issues and why?
- Explore their information needs – what information do they need to judge quality and make consumer choices?
- Explore patients' views on regulations in dentistry and the role of the GDC
- Think about the future. How patient behaviour/ attitudes might change if more information and choice is available.

Aims	Exercises	Materials needed
Ground rules/ Market Research Society Rules/ Warm up	**A. <u>INTRODUCTION (5 mins)</u>** • General introduction **Present the group with a card explaining the role of GDC as a regulator. Read out and check understanding.** **1. HANDOUT: The role of the GDC and regulation** The General Dental Council exists to protect patients and regulate dental professionals. It sets and maintains standards for the benefit of patients. This involves: • Registering qualified dental professionals. Dental professionals must be registered to practise to work in the UK. • Setting standards of dental practice and conduct which registered dental professionals must follow.	None

Aims	Exercises	Materials needed
	• Protecting the public from illegal practice. • Assuring the quality of dental education. • Investigating complaints (where appropriate) of the treatment, behaviour or service received from a registered dental professional. BRIEFLY PROMPT: • Did you know this before, or is this information new? • Does this make sense? • Does this surprise you? How? • Does this reassure you or not? • What sort of information do you think they provide to be able to carry out their role? The GDC would like to know: • Your views on the quality of service now and your priority for improvements. • How the GDC can help patients in improving services and exercising choice. • What you think of the quality of services you are receiving or would like to receive in the future. • What information do you currently receive and what information you would like to receive to help you to choose the services you want and judge the quality of the services that you receive.	
	B. CUSTOMER JOURNEY (25 mins – c. 10 mins per section) Note how people define high quality at each stage on a separate flipchart. Note what additional information would help patients to define quality and make consumer choices. **Part 1: Choosing a practice** **1. General discussion: How did you choose your current dental practice? [IF TIME]** **2. BRAINSTORM: Ask a friend [IF TIME IS LIMITED ASK PARTICIPANTS TO DO THIS AS A GROUP]** In pairs: Imagine you are new to an area and you want to know which dental practice to use. You have a friend who lives nearby to your new home. What questions would you ask them to help you make your decision?	Flip chart Case study example of complex procedure

Aims	Exercises	Materials needed
	Ask each pair to think of 3 ideas each and then brainstorm as a group. Try to get as many ideas as possible i.e. location, facilities, experience, price, the quality of the staff, services for children, complaints? etc. • PROMPT: How important is that question? • PROMPT: Who would it be important to? • PROMPT: Would a member of the public know that? **3. BRAINSTORM: Increasing access and information** **In the future, patients may be able to access more information to help them choose a practice.** **What additional information would you like to see? Write ideas in another colour.** **Why is this important?** • **Quality**; i.e. how experienced is the professional, what are their qualifications, what are they licensed to do? • **Incidents;** i.e. have there been mistakes/ problems in the past? • **Complaints;** i.e. have there been complaints in the past? • **Disciplinary record;** have they been disciplined in the past for prior incidents? • **[KEY PROMPT] Patient/ customer feedback;** what do patients think? What about a star rating system? What about "trip advisor" style information being available?* • **Cost** • **PROMPT:** How would these sources of information work/ combine with the information they currently use to choose their dental practice? ***Show examples of Amazon, Trip Advisor, NHS Choices Care and Connect (NHS Trip Advisor), and ratedpeople.com etc. to encourage participants to think about how new information could be presented and why?** • PROMPT: How important is that? • PROMPT: **Who would it be important to?** What about vulnerable groups, nervous patients etc.? • PROMPT: Would it make a difference to the way that you **choose your dental practice?** Why/ why not? • PROMPT: Would it make a difference to whether or not you **stay with your dentist/ dental practice**? Why/ why not? • PROMPT: Would you **ask your dentist/ other member of the dental team questions** about any information you see? Why/ why not?	

Aims	Exercises	Materials needed
	4. Group all the types of information (spontaneously mentioned + prompted) by their importance and relevance to patients in their decision-making around which services to use and what questions to ask. **Part 2: Ideal visit** **1. Ask participants to talk through an ideal visit.** **Write down key expectations/ desires for an ideal visit** MODERATOR NOTE: The focus on an ideal visit allows us see where improvements might be made. This is important as most patients say they are satisfied – we want to explore how much of this is related to expectations, lack of information/ knowledge and how much is related to patients receiving high quality services. **Reception** • What would this be like? • What would you expect to see? • What would you expect to happen? • PROBE ON: Information expected? The attitude of the receptionist? The environment etc. • PROBE: differences between this and a typical visit. **Seeing the dentist** • What would this be like? • What would you expect to see? • What would you expect to happen? • PROBE ON: Information provided? Patient history discussed? Communication skills? Understanding? Consent taken properly? • PROBE: differences between this and a typical visit **Follow up such as having a filling done** • What would you expect to happen? • What information would you expect? • How much choice would you expect about where to go/ who to see/ what treatment to have? • PROBE: differences between this and a typical follow-up procedure IF NEEDED/ RELEVENT: Compare differences between a follow up treatment such as a filling and standard check-up. • Why are these different? • Did you miss anything out before?	

Aims	Exercises	Materials needed
	2. RANK: We have had a number of thoughts about an ideal visit. **Would you say [x] is …** • **vital?** • **important?** • **nice to have?** Why would you say that? **Refer to flip chart for any previous mentions of high quality service.** **3. BRAINSTORM: Have we missed out anything? [IF TIME]** • Any other examples of high quality service? • Why is this important? • Moderator to sum up pointing out key themes.	
	C. POOR QUALITY SERVICE (30 mins) Explain we are now going to discuss what a poor quality service would be like. **Refer to flip chart for any previous mentions of poor quality service.** **1. BRAINSTORM: Have we missed out anything? [IF TIME]** • Any other examples of poor quality service? • PROMPT: How common do you think this is? Why? • PROMPT: How big a problem do you think this is? Why? • PROMPT: Who is affected by this problem (i.e. children, older people, nervous patients etc.?) **2. RANKING EXERCISE: Poor quality services** **For each example draw a scale showing poor quality services. Divide the scale into three parts as below** **No action required / Some action required / GDC action required** **We are going to discuss some examples of poor quality services. I would like you to use these examples to consider what kind of response you would want to happen in different circumstances.**	Flip chart Examples of poor service – based on those used in the depth interviews.

Aims	Exercises	Materials needed
	• An X-ray was not carried out as part of a diagnosis and as a result the necessary treatment is not provided • A vulnerable patient (such as somebody with a learning disability) is provided with poor care. • Patients at a/ your dental practice are repeatedly being overcharged for their dental treatment • A member of the dental team being unsympathetic to a nervous patient For each example or for as many as possible ask. **In what circumstances should the GDC become involved?** (E.g. the lack of an X-ray leads to the patient experiencing a great deal of pain, the dentist has a history of mistreating vulnerable people etc.). Aim for as many examples as possible. Allow participants to agree or disagree with each other. If necessary moderator to think of additional examples. o PROMPT: Why would you say that? o PROMPT: What would do/ want to happen if that happened to you or somebody you know? • And, what action would you want to be taken (if any)? o A formal apology o Compensation o A warning o The dental professional cautioned, fined or struck off o The dental profession provided with additional training, mentoring or observation o Additional training • What are the barriers to taking action? o Lack of knowledge o Lack of time o Concern about the dentists' career **In what circumstances should the practice or individual concerned get involved? (i.e. not severe enough to involve the**	

Aims	Exercises	Materials needed
	GDC but severe enough that some action should be taken either by yourself or the practice?) o PROMPT: Why would you say that? o PROMPT: What would do if that happened to you or somebody you know? o PROMPT: On **leaving the practice vs. complaining?** Which would you do under different circumstances and why? • What action would you expect to take (if any)? o A formal complaint o An informal complaint o Leaving the practice • And, what action would you want to be taken (if any)? o A formal apology o Compensation o A warning o The dental professional cautioned, fined or struck off o The dental profession provided with additional training, mentoring or observation o Additional training • What are the barriers to taking action? How would these be different when you are not referring something to the GDC. o Lack of knowledge o Lack of time o Concern about the dentists' career **Are there any circumstances in which no action should be taken about this** (e.g. if this was a one-off accident etc.) **or not?** If not, can you think of other examples where you might be dissatisfied but not to the extent that you would take any action? o Why would you not take any action in these circumstances? o At what point do you feel some action needs to be taken?	
	D. THE ROLE OF THE GDC AS A REGULATOR (15 mins) **Revisit action points** **1. ACTION POINTS:**	Hand out explaining the role of the GDC and regulation within dentistry.

Aims	Exercises	Materials needed
	What are the key areas within dentistry that you feel more action needs to be taken? PROMPT ON: • Information provision • Encouraging high quality standards • Disciplinary procedures **For each action point think about the GDC and prompt appropriately** • Should the GDC have a role in addressing this issue? What do you think this should be? • What do you think they are already doing about [x]? • What would you like them to do? • How should they be doing it? • What would be the advantages/ disadvantages of this? **2. FINAL THOUGHTS: [IF TIME]** • What should the GDC be focussing on in the future? What would your key message be for the GDC?	