Care Quality Commission

# A fresh start for the regulation and inspection of primary care dental services

Working together to change how we regulate primary care dental services

## The Care Quality Commission is the independent regulator of health and adult social care in England

### Our purpose:

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

### Our role:

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

### Our principles:

- We put people who use services at the centre of our work
- We are independent, rigorous, fair and consistent
- We have an open and accessible culture
- We work in partnership across the health and social care system
- We are committed to being a high performing organisation and apply the same standards of continuous improvement to ourselves that we expect of others
- We promote equality, diversity and human rights

# Contents

**Introduction from the Chief Inspector of Primary Medical Services** ........ 03

**Monitoring, regulating and inspecting primary care dental services** ........ 05

**Our priorities for primary care dental services** ........ 10

**Priority 1: Working with partners to develop a shared view of risk, agree roles and responsibilities, and identify gaps** ........ 11

**Priority 2: Improving our registration processes and ensuring that we adapt our model to meet forthcoming changes to regulations and our new enforcement powers** ........ 12

**Priority 3: Developing an approach to inspection that protects the public from unsafe care** .. 13

**Priority 4: Adopting a thematic approach** ........ 14

**What will happen next?** ........ 15

# Introduction from the Chief Inspector of Primary Medical Services

I am responsible for overseeing the regulatory activity and assessment of quality in primary care dental services, general medical practice, integrated services across health and social care, health and justice services, child safeguarding and children's services inspections, medicines management, GP out-of-hours services and the NHS 111 service.

The regulation of dental care is really important to me. Good dental care plays an important role in people's health and wellbeing. Having poor oral health has been shown to be linked with many other health diseases such as stroke, diabetes and heart disease. It also has a negative effect on an a person's quality of life, such as not sleeping or eating properly.

Today, the oral health needs of the population have changed from what they were 40 years ago. The results of the 2009 Adult Dental Survey showed a continued improvement in the nation's oral health. However, with an increase in the ageing population, and as more older people retain their teeth for longer, their dental needs will increase. I am particularly concerned about vulnerable groups of society, such as travellers, or those with impairment or disability, who often experience poorer oral health and can have more difficulty in gaining access to oral health care services. Many of these people will have high treatment needs. I passionately believe that everyone in our society deserves safe, high-quality, accessible primary dental care regardless of their circumstances.

Our inspections of primary care dental services, including NHS and private dental services, in the last two years have identified that, compared with the other sectors we regulate, dental services present a lower risk to patients' safety. Our stakeholders also agree that the majority of dental services are safe and that the quality of care is good. This was also reflected in the Steele review in 2009, which highlighted that much of NHS dentistry is already outstanding.

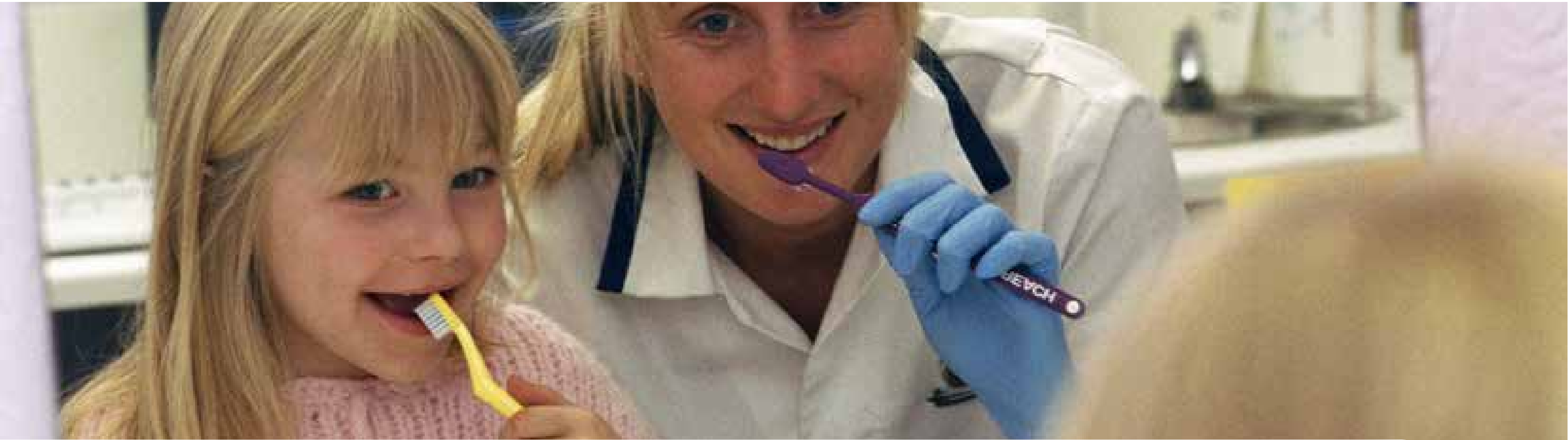
**"I passionately believe that everyone in our society deserves safe, high-quality, accessible primary dental care regardless of their circumstances"**

There are a number of organisations involved in monitoring the quality and safety of dental services and dental care professionals. We all have a mutual interest in ensuring that patients receive high-quality, safe dental services from professionals and organisations that are competent and meet national standards. I am extremely

pleased that these organisations, including the General Dental Council (GDC), NHS England, NHS Business Services Authority and CQC have agreed to work closer together to review the approach to dental regulation and inspection across England, assess current arrangements and determine an effective model for regulation for the future. My Deputy, Janet Williamson will lead this work for CQC.

We recognise the existing work of other regulatory and oversight bodies, and that the dental sector presents lower risk to patients' safety. We have therefore started to design our new inspection and monitoring approach on a less frequent model of inspection. This statement sets out our early thinking on how we will do this and how we will work with our partners.

**Professor Steve Field**
**CBE FRCP FFPHM FRCGP**
Chief Inspector of Primary Medical Services



# Monitoring, regulating and inspecting primary care dental services

CQC's role is to monitor, inspect and regulate all care services to make sure they meet fundamental standards of quality and safety, and to publish what we find to help people choose care.

In 2013, our consultation, *A New Start* set out the principles that guide how CQC will inspect and regulate care services. It set out our new operating model, which includes:

- Registering those that apply to CQC to provide services.
- Intelligent use of data, evidence and information to monitor services.
- Using feedback from patients and the public to inform our judgements about services.
- Inspections carried out by experts.
- Information for the public on our judgements about care quality, including a rating for some services to help people choose.
- The action we take to require improvements and, where necessary, the action we take to make sure those responsible for poor care are held accountable for it.

These principles will also guide our monitoring, inspection and regulation of primary care dental services, but the detail of how we do this will be designed specifically for this sector. This document describes our early thinking about how we will regulate the primary care dental sector and marks the start of a discussion about this.

We are committed to developing our approach in partnership with and listening to the voices of people who use primary care dental services, and those who provide them. We acknowledge that when we first started regulating dentists in April 2011, we did not get the model right, and as a result of listening to suggestions we made changes. However, we want to learn from what has worked well and what we could improve.

It is vital that we listen to people who use services and to local populations about dental services. We recognise that involving people in inspections is difficult in dental settings and that we will need to develop new approaches which may include joining in with other listening activities already taking place.

We are committed to working in partnership with other regulators, oversight bodies and networks to establish how these changes impact on our understanding of risk in the sector.

We are adopting the principles and key elements of CQC's operating model (shown in figure 1) to develop our new approach to primary care dental services, but some of the details will be different. We will explore with our partners how we use data and share information. We will also explore how we use Experts by Experience in our new approach, and whether or not we need a specialist adviser on every inspection.

Some of the methods we will use to regulate primary care dental services will be different to other sectors that CQC regulates. This is because of the types of risks posed by this sector and the role other regulatory and oversight bodies have. We have used the feedback from our national stakeholders to develop a resource model that, in the short term, will enable us to inspect approximately 10% of providers, starting from April 2015.

Our general model includes the ability to rate care providers on their quality of care. However, we do not intend to rate primary care dental services when we start our new approach in 2015/16. As part of the engagement work on this statement, and in discussion with stakeholders, we are seeking views on whether we should rate in the future.

## What do we mean by primary care dental services?

Primary care dental services first came into scope for registration with CQC in April 2011. Our definition of primary care dental services is: dental services that are predominantly provided by dentists on the 'high street'. Within this definition we include providers of domiciliary dental care services and any out-of-hours emergency dental services. These services come under the regulatory remit of CQC's Chief Inspector of Primary Medical Services.

There are also community dental services that provide dental treatment for adults and children who cannot be treated in an ordinary general dental practice, as well as specialist dental services provided in hospital settings. These are within the regulatory remit of the Chief Inspector of Hospitals. We are working closely with the Chief Inspector of Hospitals to align our regulatory approach to dental services where they are provided in these settings.

**FIGURE 1: OVERVIEW OF CQC'S OPERATING MODEL**

## What CQC has found since we started inspecting primary care dental services

We currently regulate 10,102 dental care locations and have inspected nearly all of them. During our first two years of inspection we inspected a selection (in most cases five) of the 16 outcomes related to the regulations. Inspectors chose which outcomes to inspect based on the information we held about the service.

We found fewer concerns compared with other providers of services we regulate. For example, between April 2011 and October 2013 we found that one in eight dental locations were not meeting the regulations in some way, compared with one in five in adult social care.

> "We are committed to working with other organisations to get a better understanding of the risks within the primary care dental sector"

The main concerns that our inspectors identified related to infection prevention and control, the way staff were recruited, how the provider monitored the quality of its services, and how the provider ensured patients were protected from abuse. Where we did identify concerns, providers acted quickly to rectify them. In the majority of cases where our inspectors re-visited the service, they found their concerns had been addressed. This is demonstrated by the low number of warning notices we have served.

Based on our inspection findings and the fact that we receive very little concerning information from the public, providers and those working within the dental sector, we believe that compared with other sectors we regulate, the primary care dental sector presents a lower risk to patient safety. However, the General Dental Council (GDC) and NHS England have reported an increase in the number of complaints about dental professionals. We are committed to working with them and other stakeholders to gain a better understanding of the risks within the primary care dental sector and, in particular, understand whether there is a link between the number of complaints and the actual risk to patient safety.

## Changing landscape within primary care dental services

Before primary care dental services came into regulation with CQC, the Department of Health conducted an impact assessment that identified the sector as being low risk and recommended that CQC inspect only 10% of providers. Since then, there have been several changes to the way in which primary care dentistry is provided. For example, there have been significant changes to the contract monitoring and quality assurance arrangements of NHS-funded primary dental practices.

In 2013, 27 NHS England area teams replaced primary care trusts (PCTs), and dental advisers were not included in the resource modelling for these teams. We know that some areas have subsequently employed dental advisers to conduct contract monitoring visits, but the full extent and impact of this is unknown.

There is now a national performers list, which was introduced on 1 April 2013 after the PCTs were disbanded. This is held centrally by NHS England rather than locally. Any dentists wishing to carry out treatment under an NHS contract must be registered on this list. This gives NHS England the power to manage these performers and protect the public from any performer who is not suitable or who falls below the required standards.

NHS England also introduced local professional networks in 2013. These clinical networks have been set up to support local clinicians to deliver the NHS and Public Health Outcomes Framework. The local dental professional networks aim to provide professional advice and leadership, working closely with area teams and other key stakeholders to improve oral health and reduce health inequalities.

NHS England is piloting changes to the way in which it commissions NHS-funded dental services. In its dental care and oral health call to action, NHS England set out the case for changes to all dental care services that it commissions. This includes a move towards a more preventative approach based on the needs of the individual patient and the population. This approach aims to focus on quality, outcomes of care, continuity of care for patients over a longer period, increased integration of care across primary, community and hospital settings, and ensuring good and equitable access to NHS dentistry.

All the above will have an impact on how CQC will monitor and regulate primary care dental services in the future.

> **"There have been significant changes to the contract monitoring and quality assurance arrangements of NHS-funded primary care dental services."**

## Characteristics of primary care dental services

Unlike GP services, dental services are not free to everyone. Charges were introduced to help pay towards the cost of the service in 1951.

### Tripartite Programme Board on the future of dental regulation in England

The General Dental Council (the professional regulator), the Care Quality Commission (the systems regulator) and NHS England (the commissioner of NHS dental care services, which also holds a list of suitable performers) have a mutual interest in ensuring that patients receive high-quality, safe dental services from professionals and organisations that are competent and meet national standards, and that services improve. Where concerns about the safety of dental care emerge, these three organisations between them have the legal powers to intervene to mitigate risks to patients and the public. However, there is currently the potential for significant overlap within this structure, as well as the opportunity for regulatory gaps to emerge.

Therefore, CQC, the General Dental Council and NHS England, along with NHS Business Services Authority, have established a Tripartite Programme Board to review the approach to dental regulation and inspection across England, assess current arrangements and determine an effective model for regulation for the future.

Primary care dental services are provided by a mix of private and NHS practices, but the majority of the population receive treatment from NHS-funded dentistry. A survey by healthcare experts LaingBuisson in 2013 estimated that 22% of the population received wholly private dental care, with 2% receiving a mix of both private and NHS-funded dental care. Latest estimates by LaingBuisson in their 2014 dentistry market report valued UK primary care dentistry at £5.8bn in 2013/2014, with £3.6bn (63%) of this spent by government and patients on NHS dentistry, and £2.2bn (37%) generated from private dentistry. NHS dental treatment may either be wholly funded by the NHS, such as for those on certain welfare benefits, or partially funded, where people pay towards the cost of treatment. The cost of treatment for those not exempt from free NHS dental care is split into three bands ranging from £18.50 to £219.

Patients who are not registered with an NHS dentist but require treatment have to pay the full cost of their treatment. Private treatment does not have set charges, so the costs vary between practices. There are a number of ways to pay for treatment, either on the NHS or privately; for example, pay-as-you-go, dental insurance, private medical insurance, cash plans, and treatment loans.

This mix of private, NHS wholly-funded and NHS private-funded dental care can be very confusing for people. In 2012, the Office of Fair Trading highlighted concerns about pricing in its dental market study, particularly that some dentists did not provide adequate information about their prices. In the 2013 Standards for the Dental Team, the GDC explicitly stated that dentists must provide clear information to patients on the cost of their treatment.

Primary care dental services are predominantly situated in local communities. They range in size from single-handed dental locations and partnerships to large corporate providers. The number and size of corporate providers is increasing. LaingBuisson reported in 2014 that 22% of the dental market is provided by corporates (groups of three or more practices).

NHS England area teams commission dental services on behalf of the local population, with over a million patient contacts with NHS dental services each week. We are aware that some population groups have issues with accessing dental services, although national data on demand is limited.

As the oral health of the population has improved and consumer interest in cosmetic dentistry has increased, many dentists have expanded the services they offer. As well as prevention and treatment of poor oral health, many dentists now provide cosmetic dentistry, such as veneers and teeth whitening. Some also offer a sedation service for anxious or nervous patients, and some provide domiciliary services to people in their own home or in a nursing home.

Primary care dental practices have varying characteristics that will inform the changes we need to make to the way we monitor, regulate and inspect providers. These include the:

- Complexity and range of services offered and the size of the dental team.
- Oral health needs of the population, including the variation of oral health in our society (oral health inequalities).
- Type of services offered, for example out-of-hours care, general dental care, sedation, NHS-funded care, private dental care, domiciliary dental care.
- Level of risk to patient safety and the quality of dental care.

> **“The mix of either private, NHS wholly-funded and NHS private-funded dental care can be very confusing for people”**

# Our priorities for primary care dental services

This signposting statement sets out our approach to inspecting and regulating primary care dental services and sets the scene for how we will work with others to develop our model in the longer term. Work is underway to look at a potential future model. This will be influenced and shaped by the work of the Tripartite Programme Board on the future of dental regulation in England (see page 8).

We are aware that there are overlaps in systems and processes used by other regulators and oversight bodies, such as the GDC, NHS England and those used by dental good practice schemes. We want to create a system where providers do not feel burdened by regulation and have confidence in our methods to ensure we regulate efficiently. We aim to make better use of shared intelligence and to take a collaborative approach with our partners to monitor dental care standards. We want to make sure that the regulatory system responds to comments and feedback from the public and from groups who represent them, such as Healthwatch.

We will also develop our understanding of our role in encouraging improvement. We will identify with our key stakeholders which aspects of dental services we need to focus on to encourage improvement. For example, it may be an approach that focuses on prevention, out-of-hours dental services, or integration with other services, such as adult social care. We will also explore a range of options, such as ratings, participation in accreditation schemes and self-assessment.

We do not intend to rate primary care dental services when we start our new approach in 2015/16, although as part of the engagement work on this statement, and in discussion with stakeholders, we are seeking views on whether we should rate in the future.

# Priority 1: Working with partners to develop a shared view of risk, agree roles and responsibilities, and identify gaps

We recognise the need to work in partnership with others to develop our new approach. In particular, we need to ensure that our definitions of quality, good outcomes for people and how we measure standards is aligned with those used by our partners. As we move towards a model of inspecting 10% of services a year, which includes random and risk-based inspections as well as inspecting when concerns are raised, we need to ensure that we target our resources for the greatest impact and do not create gaps or duplication within the system.

There is limited evidence about patient safety in primary dental care. Although CQC's inspection findings demonstrate a higher level of compliance with the regulations of the Health and Social Care Act 2008 in comparison with other care sectors, we know from discussions with our stakeholders that the number of complaints to the GDC and NHS England about dental professionals has increased.

As part of our work with key stakeholders on a long-term approach for regulation in dental services, we will find out and understand where the risks in primary care dentistry are. This group will also explore what a collaborative model to regulation would look like, and whether a joint regulatory model would work, with each organisation having responsibility for a particular area.

In addition to working with our national stakeholders, our immediate focus is to develop the way CQC shares and receives information at a local level. In particular, we will strengthen our relationship with NHS England area teams, and regional and local quality surveillance groups.

We will also work with populations in local areas to identify risk. We will do this by gathering feedback on dentists in our regional and local listening activity and through the routine contact we have with local Healthwatch, local overview and scrutiny committees, and other community and voluntary organisations. In other sectors we are exploring targeted outreach work with specific population groups; we will gather information from these groups about dentists as we pilot this activity.

> **"Our immediate focus is to develop the way CQC shares and receives information at a local level"**

# Priority 2: Improving our registration processes and ensuring that we adapt our model to meet forthcoming changes to regulations and our new enforcement powers

We will use our improved registration framework to ensure that all new providers, whether they are organisations, individuals or partnerships, have the capability, capacity, resources and leadership skills to meet the new fundamental standards and relevant legal requirements.

We intend to focus on ensuring we have a robust and effective registration system in a way that does not stifle innovation or discourage good providers of dental services, but does ensure that those most likely to provide poor quality services are discouraged from doing so.

We also want to ensure that dental care providers have a positive experience of our registration process. We know that there are particular circumstances, such as changes in partnerships, that particularly affect this sector. Our registration team dealt with over 9,000 registration applications of various types relating to primary dental care between April 2013 and April 2014. Many of these were as a result of making variations to their NHS contract. We are therefore committed to working collaboratively with NHS England and with primary care dental providers to identify more efficient and consistent ways of working to improve this aspect of the regulatory process.

We know that most people receive good care from primary care dental services. However, during our first two years of regulating dentists we identified some examples of unacceptable standards of care and used our enforcement powers to ensure services improved. We will continue to use our full range of enforcement powers if we identify poor standards of care.

# Priority 3: Developing an approach to inspection that protects the public from unsafe care

Our regulatory model for 2015/16 in primary care dental services will focus on ensuring that we are protecting the public from unsafe care by continuing to inspect against regulations and taking action where we have concerns. We will also look at how to increasingly align with our operating model for the other sectors we regulate. We will do this, by:

- Continuing to inspect and regulate against existing standards, but restructuring our reports around the five key questions of whether services are safe, effective, caring, responsive and well-led, to ensure a consistent approach with other sectors.
- Looking at how we can improve the data we hold, in partnership with others, to support the development of Intelligent Monitoring.
- Using our Experts by Experience and specialist advisers when we feel there is an increased risk to patient safety and quality of care, and where we feel that on-site clinical support would benefit the inspection.

We will explore whether there is a role for self-assessment in the regulation of the dental sector. For a minority of primary care dental services who do not have an NHS contract, there is a lack of data available that would enable us to routinely monitor the quality of care. We estimate there are approximately 1,900 providers registered with CQC who provide wholly-private dental care. We will explore how we may collect information that tells us about the quality of care they provide, for example through self-declaration or annual return. We will work with providers to develop the most appropriate way of collecting this data.

CQC has developed a new intelligence-driven model to assess the ongoing risks to the quality of care from providers, and to guide our inspection activity in hospitals. We have done this because we want to be better at predicting and preventing risks to people who receive care. This tool helps us to prioritise which services we inspect, and when, how and what we will focus on in the inspection. We will explore whether we can develop our Intelligent Monitoring for the dental sector, including specialist dental services in community hospitals. We are keen to work with our partners to share information to support this and use real-time feedback, for example from NHS Choices website.

We will explore how we involve Experts by Experience as part of inspection teams. They may be invited to conduct telephone interviews with people who use a specific service.

# Priority 4: Adopting a thematic approach

In the other services that CQC regulates, our new approach involves looking at the experiences of certain population groups. In the dental sector, we will do this by using a thematic approach.

Themed inspections are not new to CQC and there is evidence that CQC's thematic activity to date has made a positive impact. Themed inspections go beyond the 'snapshot' of services and providers gathered by a traditional inspection. They can provide an evidence base for what good care looks like and can also help drive improvement by raising issues at a national level. We will work with our partners and CQC's Chief Inspectors to explore which topics would make the biggest difference to people who use services.

Stakeholders have suggested a number of key areas, such as dental decay in children aged under five and oral care of people living in care homes.

> **"Although we don't plan to rate services at the moment, we are keen to hear what people think"**

# What will happen next?

This signposting statement sets out our initial thoughts on a new regulatory model for the sector. We want to make changes quickly but without compromising our commitment to co-production and quality. We will actively engage dental providers, patients and other stakeholders to ensure we develop a regulatory model that reflects the key characteristics, risks and quality issues of the sector, and is seen as fair, transparent and effective in helping to improve services for those who use them.

## Current proposed timeline for changes to the dental sector

- August 2014:
  - Publication of this signposting statement.
- September 2014 onwards:
  - Ongoing engagement with internal and external stakeholders.
  - Tripartite Programme Board meeting.
  - Ongoing meetings with our internal and external advisory groups.
  - Development of inspection methodology for the sector.
- July to October 2014:
  - Formal 12-week consultation on new guidance for all providers on how to comply with the new regulations and on CQC's enforcement policy.
- November 2014
  - Formal 8-week consultation on CQC's provider handbook for our new approach to inspecting and regulating primary care dental services.
- November 2014 to February 2015
  - Wave 1 and 2 inspections: testing our new inspection approach for the sector. This will include evaluation and learning.
- April 2015
  - Rollout of the new approach for the sector; this marks the formal start of our new approach and the end of the current approach.

Although this is not a formal consultation, we would like to hear your views on any of our proposals and changes that we have set out in this document. If you would like to get in touch, please contact us at **pdsinspections@cqc.org.uk**

Care Quality Commission

## How to contact us


Call us on: **03000 616161**

Email us at: **enquiries@cqc.org.uk**

Look at our website: **www.cqc.org.uk**

Write to us at: **Care Quality Commission**
**Citygate**
**Gallowgate**
**Newcastle upon Tyne**
**NE1 4PA**

Follow us on Twitter: **@CareQualityComm**


Please contact us if you would like this document in another language or format.


CQC-257-100-082014



Corporate member of Plain English Campaign
Committed to clearer communication
459