How CQC regulates primary care dental services: Provider handbook
Response from the Faculty of Dental Surgery

Overall comments

This document outlines the Faculty of Dental Surgery (FDS) at the Royal College of Surgeons' view on the regulation of primary care dental services. We are aware that the Faculty of General Dental Practice (FGDP) is also responding to the consultation and our response complements theirs. As well as detailing our responses to individual questions, we have the following overarching comments to make:

- **Inspection of private providers:** As the CQC's signposting document on the regulation and inspection of primary care dental services states, around a fifth of patients receive treatment from private rather than NHS providers. We are therefore concerned that the provider handbook does not make clear whether the CQC intends to inspect private as well as NHS providers. In our view it is essential for private and NHS providers to be treated equally by the CQC when it comes to inspecting dental services.

- **Regulating specialist dental services provided in primary care and hospital settings:** Although we welcome the proposal in the CQC's signposting statement for the Chief Inspector of Primary Medical Services to work closely with the Chief Inspector of Hospitals to align the regulatory approach to specialist dental services provided in hospital settings, we are concerned that the CQC's provider handbook does not make clear whether the CQC intends to inspect specialist dental services provided in primary care settings. For instance, orthodontic treatment and oral surgery are both provided in specialist practices in primary care settings, and in the hospital practice in secondary care settings. The proportion of orthodontic treatment and oral surgery carried out in these settings may depend on local factors, local provision, historical reasons and service development, varying in different areas, training needs and geography. As there are several areas of overlap, the standards used to measure outcomes of care in primary and secondary care should be the same where possible.

- **Information sharing:** The Francis report encouraged a greater sharing of information between the College and the regulators and we are clear that when we are made aware of issues relating to patient safety we have a professional responsibility to share our concerns with the relevant regulator. The College is often party to information about the quality of specialist dental care as a result of our Invited Review Mechanism (IRM) which provides a trust or hospital with an external expert opinion on any issues at an individual or service level. We already share information from these reviews with the CQC for surgical services, and we would be happy to provide similar information ahead of visits to hospital-based dental services.

Consultation questions

1. **CQC has a role in encouraging services to improve. For primary care dental services we intend to do this by the measures below. Do you think this will help providers to improve?**
   - **Setting clear expectations (current Guidance about Compliance and from April 2015, new guidance on meeting the fundamental standards).**
   - **Requiring providers that are not meeting the regulations to improve to the level of these standards (for example, by taking enforcement action).**
   - **Sharing information on good (and poor) practice.**
   - **Carrying out themed inspections to raise issues at a national level and gather evidence of what good care looks like to set clear expectations about good care.**

We support the measures suggested by the CQC to encourage services to improve. In particular, we agree that carrying out appropriate themed inspections will help to raise issues at a national level and gather evidence of what good care looks like. For example, the CQC could examine whether practices have the necessary facilities to provide the appropriate range of care within the primary care setting.

2. **Do you think CQC should look for examples of good practice and include them in inspection reports?**
   - **What would good practice look like and how should we work with stakeholders to develop a clear view?**
   - **How should we share good practice to promote learning between providers?**

   We agree that the CQC should include examples of good practice in inspection reports.

   Good practice could be shared through: Regional Audit Chairs/ Groups, specialty associations and Subspecialties Specialist Groups (eg British Orthodontic Society, Community Dental Service, British Society of Paediatric Dentistry etc), BDA, Local Dental Committees, Consultants in Dental Hospitals and District General Hospitals/ NHS Foundation Trust.

3. **We do not intend to rate primary care dental services in 2015/16 and intend to revisit our approach to the regulation of primary care dental services for 2016/17. Do you agree with this approach?**

   We suggest the proposal to rate dental practices should be considered carefully. We are not convinced ratings will be very meaningful to patients if only 10% of dental providers are reviewed per annum; it may be confusing to the public if a service is unrated. Any rating could also quickly become out-of-date if the same provider is not reviewed for a number of years.

4. **We have found that, compared to other sectors that we regulate, dental services present a lower risk to patients' safety and the quality of care is good. We therefore propose to inspect 10% of providers based on a model of risk and random inspection as well as inspections in response to concerns. Do you agree with our proposed approach?**

   We agree with the CQC's plans to reduce inspections to 10% of providers per year as dental services present a relatively low risk to patients' safety. It will be important to ensure that the 10% of practices being inspected covers a proportionate ratio of those providing NHS, private, specialist and community dental services treatment in primary care settings.

   However, it is difficult for the FDS to comment on whether the CQC should take a 'risk-based' approach to inspection without understanding the data and methodology that will inform this. It is extremely important that any risk analysis uses data that is up-to-date and supported by the dental profession to provide confidence in the inspection methodology. This is particularly the case given that the CQC's signposting document makes clear there is 'limited evidence about patient safety in primary dental care'. We urge the CQC to detail how they will identify 'at risk' providers as soon as possible. We would be pleased to continue to work with the regulator to support this work.

5. **For the practices that we don't inspect, how do you suggest we monitor them so that they continue to meet the regulations?**
   - **Request an annual self-declaration from providers that they meet the regulations?**
   - **Make better use of information from our partners? If so, what data do you suggest we use?**

- **Use the NHS Friends and Family Test (from 1 April 2015).**
- **Other – please specify.**

Although we agree there is a role for self-assessment in order to ensure minimum care standards across primary care dental services, this model must be provided alongside inspections. In terms of the information provided through the annual self-declaration, we understand that some practices already use a template in preparation for mock inspections and would highly recommend using something similar.

We strongly agree with a collaborative model of regulation and believe the establishment of the Tripartite Programme Board is a good step forwards. In addition, the information gathered when practices are assessed by post-graduate deaneries as part of their application to become training practices, could also be shared with the CQC.

6. **We have described the information that we will request before an inspection and the key organisations that we will work with. Do you think this is an effective approach to supporting our work? How do you suggest we gather pre-inspection information about services that do not have an NHS contract?**

   We suggest that the inspection team uses exactly the same parameters as NHS inspections for gathering pre-inspection information about services that do not have an NHS contract. This will enable comparison of data between 'NHS' providers and 'private' providers, i.e. views of people who use the private service, information from private providers and information from stakeholders for private practice.

7. **Do you think the best way to request information from providers is:**
   - **In the weeks before the inspection?**
   - **Annually?**
   - **Annually but with the opportunity for providers to update at any time?**

   We suggest the best way to request information from providers is annually but with the opportunity for providers to update at any time, together with a reminder to ensure the information is up to date in the weeks before the inspection.

8. **We have described the ways in which we could gather the views of patients. Are there any other ways to gather views about the quality and safety of primary care dental providers?**

   We are keen to work with the CQC to define what 'quality' is before they start to try to measure it. This measurement of quality must be expressed in a way that patients will understand and that also has professional credibility.

   We also recommend that qualitative and quantitative outcome measures should be used to gather additional views about the quality and safety of primary care dental providers. This could include Patient Reported Outcome Measures (PROMS); Patient Reported Experience Measures (PREMS); and clinical factors such as longevity of restorations or Peer Assessment Rating (PAR) scores (orthodontics).

   As FGDP have stated in their response, whilst the CQC does not operate outwith England, it is worth noting that the other UK countries have good systems in place for monitoring NHS treatments via analysis of claim forms (eg, the GP17 in Scotland). Data relating to Units of Dental Activity may be helpful, such as failure to meet targets. The CQC may also find it helpful to look at

additional qualifications gained by providers, as this demonstrates continuing interest in further education and is may provide an indication of improved patient care. Also, random sampling via a questionnaire survey designed and administered by CQC to cover the key areas may also be useful.

9. **During our inspections of primary care dental services, the size and composition of our inspection teams (for example, including a dental specialist or Expert by Experience) will be determined by the risks we have identified in our planning. Do you agree with this approach?**

   We strongly recommend there should be a dentist on every inspection team to ensure that those with expertise are able to spot issues that non-dentists may not notice. Moreover inspection teams should include dentists with relevant experience in the type of practice being investigated. Dentistry is becoming increasingly complex, and many General Dental Practitioners have particular areas of specialisation.

   In addition, the term 'dental specialist' should be clarified, as it is generally understood by those working in dentistry to mean a practitioner on the GDC specialist list, rather than a dentally-qualified professional on an inspection team.

10. **We have mapped the regulations to the five key questions that CQC asks of services, do you agree with our mapping? (See the appendix.)**

    Yes we agree with the way that the regulations have been mapped to the five key questions that the CQC asks for services.

11. **To ensure a consistent approach to inspection, we have developed a set of prompts for our inspectors. Do you think these questions will enable inspectors to judge whether or not a provider meets the regulations?**
    - **Are the prompts relevant and do they ask the right questions?**
    - **Is there anything missing from the prompts?**

    Yes we agree the prompts are relevant and ask the right questions.

12. **We have provided examples of the evidence we may look for during our inspections. Do you feel confident that this will identify any areas of poor quality care?**

    Yes we agree that the examples of the evidence the CQC will look for during inspections will help to identify areas of poor quality care.

13. **As part of this consultation we have published a Regulatory impact assessment and an Equality and human rights duties impact analysis. We would also like your comments on these.**

    We welcome the inclusion of the Regulatory impact assessment document as it provides an overview of the process to date and the reasons for and potential benefits of, the proposed revision to the inspection process. It also provides useful guidance on the direction of travel in terms of regulation.

    We also welcome the Equality and human rights duties impact analysis document as it provides clear, evidence based, guidance on the key areas for review and ongoing improvement.