CQC's new approach to inspecting and regulating dental providers

12th June 2015

John Milne & Sampana Banga

CareQuality Commission

CQC purpose and role

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

The scale of regulated care

Care Quality Commission

General public

53 million (35 million adults)

Private hospital

1.4 million people receive treatment in a private hospital per year

Dentists

- **22 million** on a dentist list
- 15 million NHS
- 7 million private

Health & social care staff

- 1.7m NHS staff
- 1.5m in adult social care

Care homes

- **565,000** residents
- 400,000 current residents
- 165,000 going into care per year
- 39,000 people with severe learning disabilities in residential care
- 18,000 in a care home or care in their own home with no kith or kin

GP practices

- **52 million** registered with a GP
- 150m appointments per year

Home-care

700,000 people receiving home-care support per year

NHS hospitals

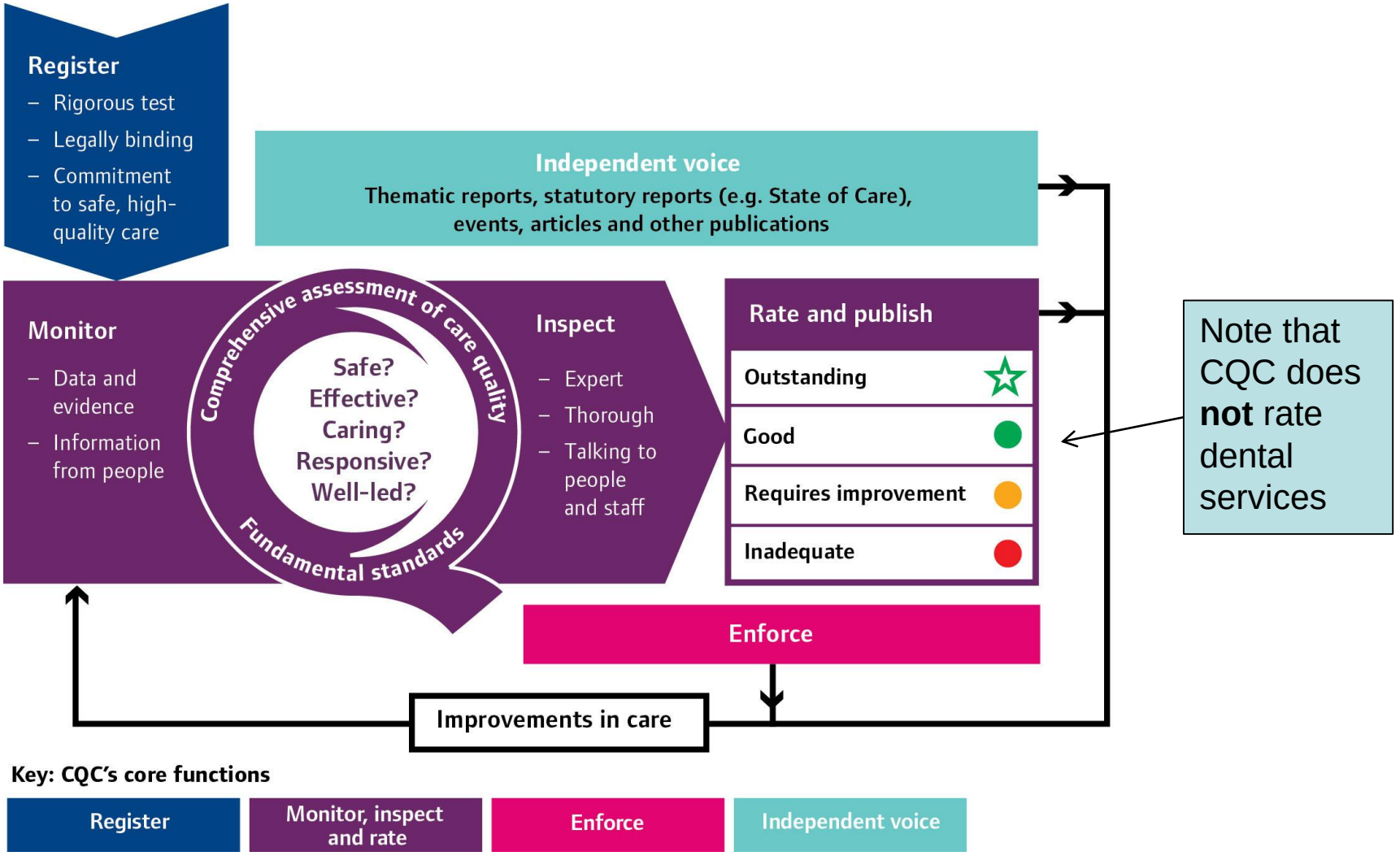
- 90 million outpatient appointments per year
- 11 million inpatients per year
- 18 million A&E attendances
- 5 million emergency admissions/year
- 600k maternity users
- 42,000 detained and treated against their will

NB There is overlap between our different audiences – none are wholly distinct from the others

Why bother?

Good?

Our new approach



What are we doing differently?

- Asking if the service is safe, effective, caring, responsive and well-led
- **Specialised inspection teams**: Specially trained dental inspectors along with Specialist Advisors
- **Involving people in our inspections**: Gathering patient views before and during inspection.
- Spending **more time** at the service
- A clearer approach for **responding to failing services**
- During our first year of the new approach, we will be inspecting **10% of the sector** (approx 1,000 providers)
- We **do not rate** dental providers

How do we encourage improvement?

Care Quality Commission

Look at whether dental practices are safe, effective, caring, responsive, well-led based on the fundamental standards of care

Provide clear guidance and prompts

Share notable practice and promote learning between providers

Report on examples of notable practice within the narrative of our inspection reports

Our key questions

Is the quality of care:

- **Safe?** people are protected from abuse and avoidable harm.
- **Effective?** people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.
- **Caring?** staff involve and treat people with compassion, kindness, dignity and respect.
- **Responsive?** services are organised so that they meet people's needs.
- **Well-led?** the leadership, management and governance of the organisation assures the delivery of high-quality care, supports learning and innovation, and promotes an open and fair culture.

Fit and Proper Person Requirement

Fit and Proper Person Requirement

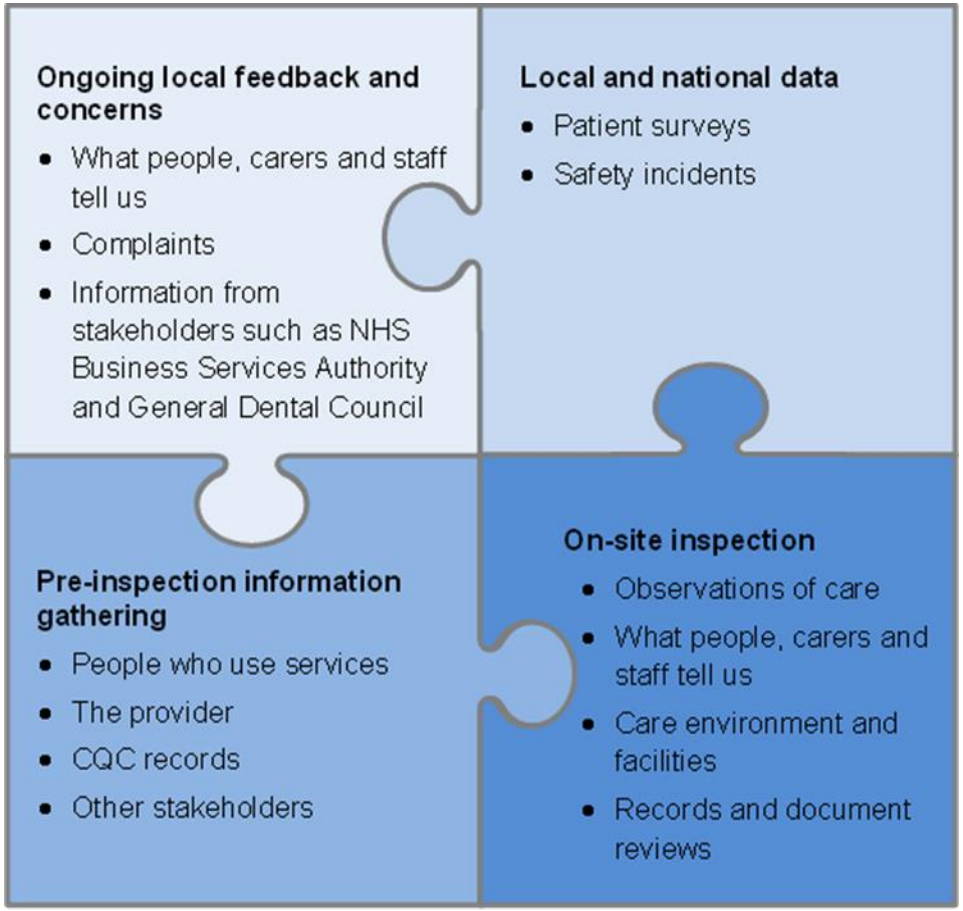
- Providers must take proper steps to ensure that their directors (both executive and non-executive) are fit and proper for the role.
- Directors must be of good character, physically and mentally fit, have the necessary qualifications, skills and experience for the role, and be able to supply certain information (including a Disclosure and Barring Service check and a full employment history).
- Those who are unfit will include individuals on the children's barred list or the adults' barred list. They must not be prevented from holding a director's post under other laws like the Companies Act or Charities Act.

Duty of Candour

Duty of Candour

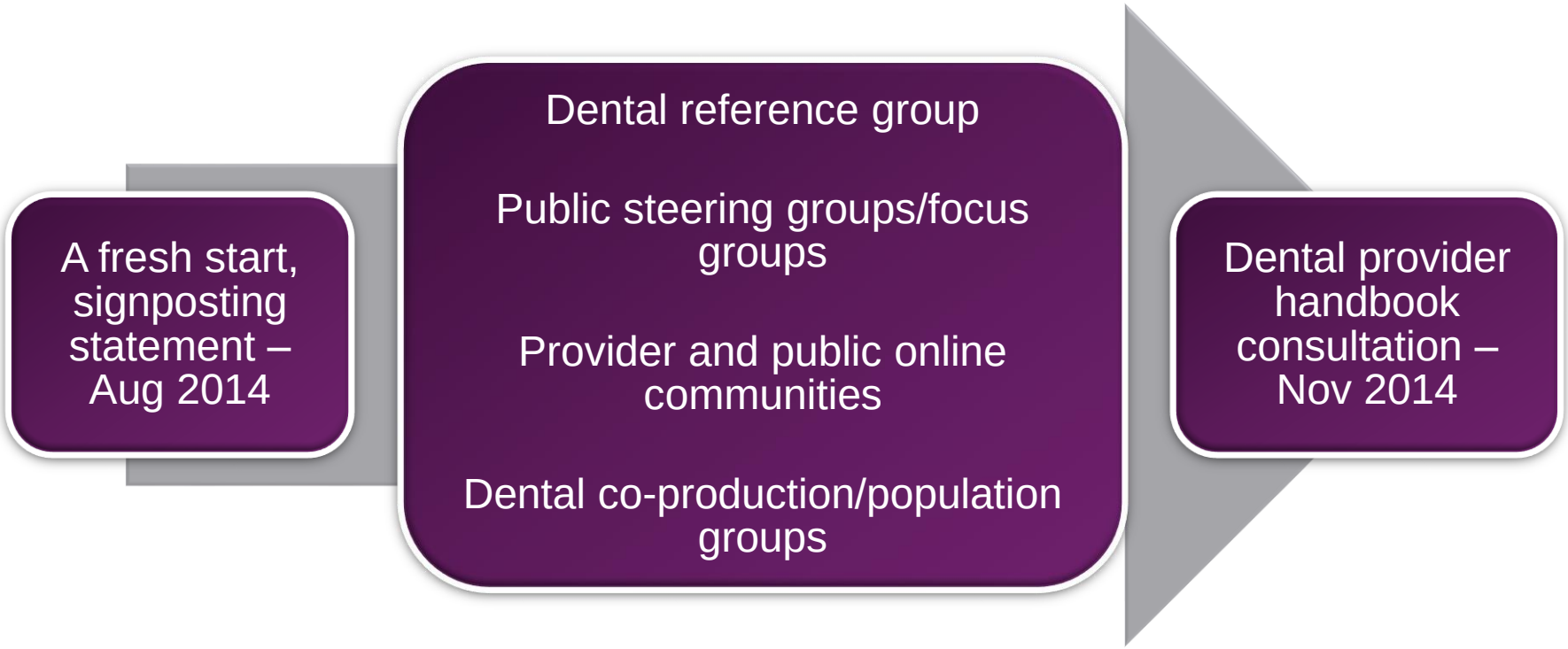
- Providers must be open and honest with people when things go wrong with care and treatment. Providers must give them reasonable support, truthful information and a written apology.
- Providers must have an open and honest culture at all levels and have systems in place for knowing about notifiable safety incidents. The provider must keep written records and offer reasonable support to the patient or service user in relation to the incident.

Sources of evidence



Developing our new approach to inspecting dental services

We co-produced the changes by working closely with our partners, providers, key stakeholders, the public and people who use services:



What to expect from an inspection

- We send you a letter two weeks before we inspect (unless we are responding to concerns) and our inspector will call
- On the day, we ask you to tell us (and provide evidence) about the care you give
- We want to talk to staff and patients to find out more
- After the inspection, we will tell you our initial thoughts
- We write up our report and sent to you for factual accuracy checking
- We publish on our website

How we report

- Our reports address the five key questions; are services safe, effective, caring, responsive and well-led?
- Where we identify concerns, we take proportionate and necessary action
- Where the concern is linked to a breach in regulations, we employ a range of enforcement powers
- We celebrate evidence of notable practice that goes above and beyond our expectations of good care – we let providers know and share it publicly

CQC- Pro-active in regulation.

- Our main priority is to carry out an assessment of the quality of primary care dental services leading to a judgement about whether they provide people with care that is safe, effective, caring, responsive and well-led, based on whether the regulations are being met.
- The future model from 2016 onwards will be influenced by the joint work of the ‘future of dental regulation programme board’ which is made up of members from: GDC, NHS England, NHS Business Services Authority, Healthwatch England, the Department of Health and CQC.

Regulating Primary Care Dental Services – Case Study

EXAMPLE

- Whistleblower contacts NHSE Area Team with concerns.
- NHE Area team ask local CQC contact IM to consider whether concerns expressed by whistleblower are sufficiently concerning to CQC to trigger an inspection.
- Considered by local CQC team and a responsive inspection planned.
- Responsive inspection undertaken and significant environmental concerns found.
- Management Review Meeting (MRM) determines that we need to act in order to minimise the risk to patients.
- View of the dental adviser on Inspection is that the concerns are remediable. This view is supported, on the basis of the evidence in the report, by dental advisers in the MRM.

Regulating Primary Care Dental Services – Case Study

KEY MRM QUESTIONS

A: Is the Dentist capable of change?
Is the Dentist willing to change?

It was determined that the answers to these questions would best be put to the Dentist by the Head of Inspection.

B: Is there any support available to help the dentist make the necessary changes?

It was agreed in the MRM that this was a question best put to the clinical lead at the NHSE Area Team.

Regulating Primary Care Dental Services – Case Study

RATIONALE

The responses to these questions were key to the decision making of the MRM.

If the answer to both sets of questions was YES then the decision regarding the most effective means of mitigating the risk of harm to patients would be to SUSPEND the practice until the necessary improvements had been made.

If the answer to both sets of questions was NO then the decision regarding the most effective means of mitigating the risk of harm to patients would be to CANCEL the registration of the practice.

Regulating Primary Care Dental Services – Case Study

OUTCOME

Discussion with the Dentist:

We had the dentists contact details on file. This was illuminating and definitely the right thing to do. The dentist was passionate about the practice and was determined to fight for its future. During the course of the discussion the dentist mentioned that they were unhappy at the decision and would be contacting the BDA as they were a member.

Discussion with the NHS Area Team:

We did not have the relevant contact details on file.

The PA of the clinical lead asked me to put my query in an e mail. She very helpful made sure that the clinical lead saw the message as he was in a meeting. The clinical lead got the message and suggested I contact a colleague in the Area Team.

I contacted this person's office spoke to the PA as the contact was in a meeting. The PA kindly made sure that this person saw my request and the PA came back to me with a suggestion that I contact the Deanery along with a contact name and e mail address. The person was on Annual Leave.

Regulating Primary Care Dental Services – Case Study

LESSONS

- Important to have a current contact list for key individuals in partner organisations.
- Important to have a ‘protocol’ in place outlining who to contact in the case of urgent action.
- Important to have an understanding of the role of Area Teams in supporting practices in difficulties.
- Important to know who in the local community a dentist in difficulty can turn to for support.
- We need to be consistent in our approach to NHS practice as well as private practice.
- A communications lessons learnt has taken place and we need to build on this.

Thank you

www.cqc.org.uk

John.milne@cqc.org.uk

enquiries@cqc.org.uk

@CareQualityComm @CQCProf

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