



The future of dental service regulation



Regulation of Dental Services Programme Board

Supported by Healthwatch England and the
NHS Business Services Authority

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Contents

- Foreword 2
- Introduction..... 3
- Key findings 4
- The current system 6
- Opportunities for change 8
 - 1. Roles and responsibilities of regulators 8
 - 2. Joined-up model for regulation of dental services..... 9
 - 3. Improved data and intelligence 10
 - 4. Complaints..... 12
 - 5. Support for quality improvement..... 13
 - 6. Improved communication with providers..... 14
 - 7. Improved communication with the public 15
- The way forward 16
- Appendix A: Regulation of Dental Services Programme Board Terms of Reference 18
- Appendix B: Roles and responsibilities of member organisations 21
- Appendix C: References..... 23

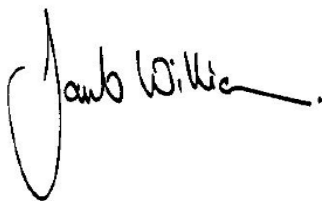
Foreword

Dental health in England is improving. Many more people are retaining their teeth for life, and today's children are far less afflicted by dental decay than their parents and grandparents were. In health terms, dentistry is a great success.

Nevertheless, there are significant challenges in dentistry that need to be faced. Older people who have kept their teeth may well have had large amounts of complex treatment, which is difficult to maintain. Young children in deprived areas suffer high levels of disease and many need to be treated in hospital where teeth are extracted with general anaesthesia.

Dentists feel over-regulated. A dentist might find themselves being investigated by the General Dental Council, who are concerned about fitness to practise; the Care Quality Commission may investigate the safety and quality of the practice, while the NHS may also question whether services are being delivered according to the regulations. This multiple intervention and potential duplication of effort is both wasteful and stressful and can have far reaching professional and personal consequences for those whose performance is a cause of concern. There is a need to think differently and ensure that any regulation is focused where improvement is required and where we can measure a difference in encouraging improvement.

For the first time ever, the regulators have met together over the last 12 months to discuss how the burden of regulation in dentistry might be reduced, whilst still providing the protection that the public rightly expect. We have consulted widely with stakeholders, particularly with the dental profession and patient representatives. This report analyses the current position and proposes agreed actions to enable dental regulation to be more coherent, more streamlined and more effective in the future. Each of the regulators is committed to collaborative effort to improve dental regulation for the benefit of both patients and the profession.

A handwritten signature in black ink, appearing to read 'Janet Williamson', with a long horizontal stroke extending to the right.

Dr Janet Williamson
On behalf of the Regulation of the Dental Services Programme Board

Introduction

Changes to the health and social care landscape – and the regulatory landscape for dentists – have provided an ideal opportunity to review and improve the overall approach to dental regulation in England.

The Regulation of Dental Services Programme Board was established in September 2014. It is formed of the following organisations who all have a role and responsibility for setting, managing and regulating the provision of dental care in England:

- Care Quality Commission (CQC)
- Department of Health (DH)
- General Dental Council (GDC)
- NHS England.

Its work is supported and underpinned by:

- NHS Business Services Authority (NHSBSA)
- Healthwatch England and the local Healthwatch network.

All have an interest in ensuring that patients receive high-quality, safe, dental services, which seek to improve continuously.

This marked the first time that national organisations have come together to discuss dental regulation. The Board's agenda is to focus on dentistry regulation as a collective body and review the approach to dental regulation and inspection in England, as well as determining an effective model for the future.

We have identified a number of findings over the last 12 months and, in this report, are jointly proposing both short and medium term opportunities for improvement. We will continue to engage with the dental profession and the public on the way forward for the future in an open and collaborative way. Regulation is important to check that people receive safe dental services, to hold providers to account, and to encourage improvement. Regulators also have a responsibility to be transparent. In the last 12 months, we have developed a good, open and honest dialogue with stakeholders, but it is not always clear what the risks are and what needs to improve in terms of the quality and safety of dental care in England.

We held two stakeholder events in March and June 2015. The feedback we received told us that the system for the regulation and commissioning oversight of the provision of dental services isn't working as well as it could. There is perceived to be duplication between the different regulators. It is difficult for patients to know where to find information about services and to know who to talk to when care does not meet

required standards. Dental stakeholders feel that the stress put on dentists by the regulatory system is disproportionate to the level of risk to patient care.

This report marks the first stage in a process of reviewing the future of dental service regulation. It is also part of the process in establishing greater public and professional confidence and will help to continue that discussion.

Key findings

All organisations with a role in setting standards, managing NHS contracts, and regulating the system for the provision of dental care in England show a commitment and genuine willingness to work together more effectively and efficiently. This represents a new way of working and a recognition that the current system can be complex and confusing for dentists and for the public.

This system for regulating dentists has grown organically rather than by design, which has resulted in both overlaps and gaps appearing across the system. There are some obvious areas for improvement; some of which can be achieved immediately and some that will take longer. These are set out in this report. However, there is still work to be done by the Board in collaboration with stakeholders to determine what the system could, and should, look like in the future. What we are clear about is that the features of the current system present the following issues:

- There is no clear definition of roles and responsibilities, with limited understanding between organisations of who does what, when and how. Consequently there is risk of duplication and inefficiency within the system.
- There is no clear model of regulation. The changes in the commissioning context, combined with the introduction of system regulation, have led to a confusing system with incoherence as to the relationship between performance management and regulation.
- There is limited data sharing to manage risk proactively and learn from what is improving. There is no common data set on quality and safety to enable regulators to establish overall safety of dental services across England. The current model of regulation is also not underpinned by a common data set of information sources that we all use, and it isn't clear how we currently share them. Therefore, there is no common understanding of risk, what flags as a risk and which is the best organisation to deal with the issue. This is compounded by the difference in data available for NHS dentistry in comparison to private practitioners.
- When complaints arise, or issues such as infection control surface, there is potential for the same dentist to be scrutinised by three organisations (CQC, GDC and NHS England) for the same issue, all of whom have the power to impose significant sanctions. Other bodies may also inspect dental practices, for example, Health Education England and Public Health England.

- There is limited support for quality improvement across the regulatory system. There is a lack of clarity as to who leads on supporting 'failing' practices/ vulnerable practitioners and for improving quality more widely across the dental sector.
- There is limited communication with dentists and patients. We do not communicate with our key stakeholders in an effective and sustained way.

Some of these issues can only be fully addressed when we have put some of the initial recommendations in place, especially clarity of roles and responsibilities and the data to support the overall picture.

It is important to note that the Board has undertaken this work to look at the issues of regulation as set out in the terms of reference; as such it is not intended to be the repository for all issues relating to dental service delivery. The discussion at times has inevitably touched on topics such as NHS contract reform, but we have kept our focus on the role and remit of the Board.

We have identified areas where the system doesn't work effectively and will work with stakeholders to make changes and identify better approaches. We recognise that this will require input from members outside the Board. We committed to publishing our thinking and our findings after a year and we welcome your continued engagement as we continue our work with your help.

In order to address these issues, we have identified areas where progress should be made over the next year. Stakeholders told us that any future design/model should be based on a number of clear principles. This must be the foundation on which we make changes. We will follow the principles set out below, which were agreed following input from our stakeholders, and use them to underpin our future work.

Principles for the system:

- Patient focused.
- Simple and transparent.
- Clear accountabilities.
- Efficient and cost effective.
- Embeds partnership working.
- Improvement focused.
- Supportive.
- Local resolution as a first stage.
- Based on mutual understanding and sharing.

The current system

The Board started its work by focusing on how the overall system of regulation fits together. Research was commissioned by the GDC. Its purpose was to develop a clearer understanding of the current processes for regulating and performance managing NHS primary care dentists, and how these processes relate to the wider system of regulation. The research (Birmingham, 2015) consisted of a web survey with staff within the GDC, NHS England, NHSBSA and CQC, as well as interviews with performance leads within the NHS area teams. A total of 84 people completed the web survey. Sixteen people were interviewed from the area teams. The findings of that research are referenced later in this report.

The Board considered previous experience of partnership working within the hospital and general practice settings and in particular the experience of implementing a Joint Working Agreement between the General Medical Council (GMC) and CQC.

We have also noted the recent publication of the Professional Standards Authority report, *Rethinking regulation*, which argues that the regulatory framework for health and social care “needs radical change”.

The current system of dental regulation was not designed from a blueprint, but developed over a number of years, with layers of regulation being revised or added. Many who work in the system believe that more can be done to delineate the roles and responsibilities of each organisation, and dental professionals frequently express concerns that the overall system of dental regulation is fragmented, overly burdensome, and inefficient. They also believe that the professional regulator deals with too many issues that could better be resolved at local level.

Until now, there has been no review of the system to see if it is working effectively, to recognise the changes within the system and to view their impact at strategic and operational level.

The roles and responsibilities of the main organisations in the system for regulating dentists are as follows:

- The General Dental Council (the GDC) is the statutory regulator of dentists and dental care professionals in the United Kingdom. Its main objective is to protect patients and the public. It sets standards for dentists and dental care professionals, provides guidance and takes action against professionals who breach the standards. It also sets standards for dental education and training.
- NHS England is responsible for commissioning NHS dental services and for carrying out contractual compliance and performance monitoring. A national performers list managed by NHS England was introduced on 1 April 2013 after primary care trusts were disbanded.

- The Care Quality Commission (CQC) is the system regulator for dental practices. It monitors and inspects dental practices and checks whether dentists are providing services that are safe, effective, caring, responsive, and well-led, in accordance with regulations.

Regulatory framework

The roles of these three organisations are governed by five separate pieces of primary legislation:

1. General Dental Council: Dentists Act 1984 (as amended).
2. Care Quality Commission: Health and Social Care Act 2008.
3. NHS England: NHS Performers List Regulations 2013.
4. NHS England: NHS (General Dental Services Contracts) Regulations 2005.
5. NHS England: National Health Service Act 2006 (The Functions of the National Health Service Commissioning Board and the NHS Business Services Authority) Primary Dental Services 2013.

In addition, legislation governing all of health and social care – the Safeguarding Vulnerable Groups Act 2006 – creates the Disclosure and Barring Service, which has powers to prevent dental professionals from working within the health service.

Each piece of legislation sets out different statutory duties for each organisation but broadly speaking they are aimed at:

- Establishing standards of dental care to protect patients and the public.
- Managing the performance and delivery of dental care.
- Providing ways to intervene when standards are breached or where performance is inadequate.

The Board also included two other partner organisations with an interest in improving the current system. NHSBSA, formerly known as the Dental Practice Board, was established in 1948 to assess claims from dentists for payment for NHS services and, since 1990, has taken a role in monitoring and investigating inappropriate treatment activity by NHS dental contractors. Since 2011, when CQC's role came into being, NHSBSA changed the way it monitored dentists from a routine practice inspection approach to a pure risk-based approach using clinical advisors.

The Healthwatch network provides insight into the experiences of those using health and social care services to help drive improvement. Covering 152 local authority areas, local Healthwatch have been speaking directly with their communities about dentistry and reported their findings to Healthwatch England. As the national consumer champion for health and social care, they ensure this evidence, and the trends it highlights, is being used to shape the future of NHS dentistry services.

Opportunities for change

Our work has identified the following seven areas for change and action.

1. Roles and responsibilities of regulators

The lack of clarity about roles and responsibilities leads to duplication and confusion in the system. There is ambiguity about respective organisational regulatory processes even within organisational teams, which limits effective communication and resolution at a local level.

People working in the GDC, CQC, NHS local teams, and NHSBSA find it difficult to understand the regulatory processes of partner organisations. Issues are potentially not being resolved at local level where possible (for example, complaints) or dealt with collectively with a proportionate response.

From the perspective of the dental professional, there is a lack of clarity and often misunderstanding about which organisation does what. One stakeholder, referring to the level of burden and scrutiny by regulators and commissioners stated, *“you say its low risk but it doesn't feel low risk.”*

Furthermore, there is a lack of formal connection between organisations, so it can be unclear who is responsible within each organisation. This is often compounded by changes of employees within organisations, resulting in occasional breakdowns of communication within the system.

We are aiming to be more effective and efficient. It is important for organisations to set out clearly what they do. This isn't just about the organisations that initially sat round the table to form the Board, but includes others – especially Health Education England in terms of the education, training and support they offer to the dental team.

Area for improvement

Define respective roles and responsibilities in system. A joint working protocol should be developed and monitored between GDC/NHS England/CQC, with clear thresholds so that everyone in the system understands their roles and responsibilities. **This will be done by October 2016.**

In order to remove overlaps and set boundaries between organisational roles, these need to be clearly set out, transparent and visible to all. Stakeholders told us this would be most easily reflected in a formal agreement between regulators.

2. Joined-up model for regulation of dental services

Our stakeholders told us that they are supportive of regulation but there are too many organisations that carry out inspections (CQC, NHS England, and Health Education England).¹ Overlap causes unnecessary stress and burden on providers.

The role that inspection plays within the system is not clear or joined up. Some dental practices can be inspected three times by different bodies. Stakeholders felt that there was a confidence issue, as each organisation is risk averse, which results in duplication. Both of these elements were supported by the research findings.

The web survey revealed that there was a lack of clarity about which organisation should deal with a particular issue (for example, infection control, overcharging, single patient complaints, fraud). There was inconsistency about whether each organisation should deal with it on its own, refer it on to another organisation or deal with it jointly with another organisation. This is highly inefficient, meaning that some organisations are potentially getting involved in issues that can and ought to be dealt with by another organisation. This also leads to duplication of effort and can be confusing and frustrating for dental professionals.

In the absence of systematised data on quality and safety of dental services across the system, it is not possible to quantify how safe they are. For example, CQC carries out regulatory inspections with very limited data from regulatory partners from which to plan their inspection portfolio. Similarly there is no data demonstrating the impact of regulation on quality improvement, making it hard to measure the impact of regulation. This has prompted CQC to think about its current inspection model and whether there are effective alternatives, such as forms of self-regulation.

The Francis report (Francis QC, 2013) called for collaboration between professional and system regulators and the NHS to promote and protect patient safety. We need to consider how collaboration within dental regulation can be optimised. This includes developing a transparent approach to regulation, with the right issues considered by the right organisations in a timely manner, with a shared understanding of roles. There needs to be clearer boundaries between what the various organisations do. We need to look at the whole system to spot gaps and determine which organisation should fill them.

At the simplest level, conversations need to take place between regulators and commissioners. Regular discussions should take place to determine who is best placed to carry out the work and how.

¹ This isn't an exhaustive list as other organisations, such as the Health and Safety Executive and the Medicines and Healthcare products Regulatory Agency, have power of entry.

The Birmingham University research found that the links between the GDC, CQC, NHS England, and NHSBSA organisations at local level are poor. Some consideration needs to be given to what structures can be put in place to move regulation, where appropriate, from national to regional and local so that local concerns can be addressed in a joined up way, whilst still demonstrating national consistency.

Area for improvement

Define a clear model for the system of dental regulation that ensures strategic/national alignment with local partnership working. **This will be done by April 2016.**

This model should outline a clear framework for risk assessment/methodology. **This will be done by April 2017.**

3. Improved data and intelligence

Data and intelligence have a vital role to play in any system of regulation. They:

- Identify the status of individuals or bodies that are subject to regulation (for example, GDC register).
- Enable the regulatory system to identify and investigate breaches and also identify where performance does not meet agreed standards of care and service delivery.
- Give visibility and transparency to everyone who wants or needs to know the outcomes of the regulatory system (for example, suspension from the GDC register).
- Enable patients, regulators, dental professionals and commissioners to raise concerns or potential risks to appropriate standards of care, or service delivery.
- Enable the system of regulation to improve continuously and evolve.

The research found that different organisations had some difficulties in accessing key data from other organisations when carrying out their regulatory activities (for example, fitness to practise history, the place where a dentist works, their performers list number and details). This is in part because the data isn't in a format that everyone can access. However, lack of data sharing and understanding of the purpose and function of each organisation's data was also a common theme in discussions.

A lack of clarity regarding information governance results in organisations at a local level acting in a risk averse way. Staff within organisations may be uncomfortable with not investigating an issue, or not referring a case on. There is a need for greater clarity at national, regional and local level regarding data sharing.

Risk is also understood in different ways. Firstly, the areas of risk for the public might be easily separated into structural, clinical and financial in terms of value for money. In terms of structural, this mostly relates to environmental factors such as: is the practice clean? is infection prevention and control adequate? is the equipment fit for purpose, maintained and used properly? - most of which comes under the area of 'safe' in CQC terms.

Put simply, clinical risk might be expressed in terms of whether examination and diagnosis are carried out diligently, using current evidence and guidelines; whether patients are fully involved in treatment decisions, and whether those treatment decisions made in the best interests of the patient. In other words, it is important that patients are offered care and treatment appropriately – neither neglected, nor over-treated. The NHS oversees in the region of 10,000 primary care dental contracts and collects a large amount of information that enables trends to be identified at practice level, and sometimes practitioner level. This data can be analysed and can give a good idea about whether diagnosis and treatments are effective. This data also helps to ensure value for money by identifying where services might be over-claiming and can also indicate whether patients are being charged correctly. However, it is recognised that little of this data gives an indication about the actual quality of clinical care. Private routine dental care carries similar risks, but data is more difficult to obtain.

In order for the system to focus effectively on higher risk practices and performers, regulatory action needs to be informed by accurate and reliable data and information that can be easily used by case workers, inspectors, clinical advisors and performance leads. Ensuring that each organisation can access relevant information in a format that makes sense to them is something that could be addressed through the development of common datasets and the use of the same identifiers.

Organisations that hold data (CQC, NHS England, NHSBSA, and GDC) could pool data and analytical resources to create a single source of information. Qualitative intelligence, such as the Friends and Family Test, also needs to be connected in to the system to regain the local element.

The gap that we have identified in information about private practices could be addressed by greater use of established dental accreditation schemes combined with a system for self-reporting to capture corporate data, whilst being mindful of the burden any such system would impose. Drawing more on the theme of self-regulation, there is the potential for some sort of self-report or declaration that meets the needs of both CQC and NHS England, so that it reduces existing separate data requests and comprises a meaningful assessment of quality by each practice. The benefit of having a central source or repository of information for the use of data and data sharing has been widely recognised. One suggestion is that, potentially, all level of concerns/issues/complaints could be handled through a single portal and escalated to other organisations accordingly – for example, passed to the GDC if a serious fitness to practise issue etc.

The Professional Standards Authority report challenges that “the absence of a consistent risk-assessment methodology is manifest in the current structures of statutory regulation”.

So how could we resolve this in practice to ensure that we are looking at the right measures and triggers in the first place? The starting point must be to share information in a much more systematic way and to enhance levels of trust between regulatory partners.

Area for improvement

Improve data and information/intelligence sharing, including proactively, to plan inspection programme and share learning. **This will be done by April 2016.**

Establish data sharing agreement with a longer term plan to establish a central source of information for the repository of data and data sharing. **This will be done by October 2017.**

4. Complaints

The confusion about which body handles complaints, what the process is, and whether it is in the best interest of patients, is a symptom of the wider issues within the system. To highlight how confusing the complaints system is, Healthwatch England pulled together an atlas of the complaints system (on page 19 of the full ‘Suffering in Silence’ report).

How to complain is confusing for patients. Information about how to complain is often not readily available and often patients are reticent about complaining as they fear it will affect their care. This is of particular concern in dentistry because of limited access to surgeries that are registering new NHS patients in some areas and continued misunderstanding about the existence of dentist registers.

The issue of complaints in dentistry is uniquely complicated due to the mixture of NHS treatment, patient charges and private treatment. This creates confusion for the patient and blurred lines of organisational responsibility about which is best to deal with the complaint and whether or not any support will be made available to the patient.

The Dental Complaints Service, funded by the GDC, provides impartial advice and conciliation for private dental patients and dental professionals who have not been able to resolve a complaint locally about private dental treatment. The Dental Complaints Service handles complaints that do not raise issues of fitness to practise. Stakeholders were generally very positive about this service. The problem arises when complaints enter the system and organisations are simultaneously dealing with the same issue. For example, CQC does not settle individual complaints about health services but feedback about a practice helps it to decide when, where, and what to inspect.

The GDC can only deal with issues of fitness to practise elements and has experienced a substantial increase in the number of complaints received over the last few years.

Our stakeholders told us that there should also be more emphasis on arbitration and getting a good outcome for the patient/complainant, which is not usually achieved through fitness to practise proceedings. They also told us that it would be desirable to have one complaints channel – even perhaps one national telephone number that can signpost complaints to the appropriate place. Local Healthwatch has a role in directing consumers to the correct complaints channel to use.

It was also highlighted that complaints and other feedback about care are a source of wider learning and that more could be done to bring together and share learning from complaints, concerns and other feedback.

In order to improve communications to patients and make the process simple and straightforward, we need to be clear about what each organisation can deal with. A single complaints system may be a longer term consideration, but signposting can be improved in the short term, particularly with the aim of improving engagement and timely intervention seeking to encourage resolution at local level.

Area for improvement

Defined system with recognised roles for complaints handling, supported by clear signposting processes. **This will be done by October 2016.**

5. Support for quality improvement

Where issues of quality or performance are identified, there is limited and inconsistent support available to help dentists to improve services. By this, we mean there is little support for 'failing' practices/vulnerable practitioners and in the general context of quality improvement more widely across the dental sector.

Some organisations have stated roles in relation to improvement –CQC encourages improvement, NHS England commissions improvement, and the Healthwatch network looks to shape improvement around people's wants and needs. Yet none of these organisations has a responsibility to facilitate such improvement at a practice level or at wider system level.

Our stakeholders told us that they felt the burden of regulation caused by duplication of effort had increased the level of stress within the dental sector.

There was strong agreement that there was a need for more universal support for dental professionals. Stakeholders cited support for the previous approach where the PCT dental advisor did the supporting and others did the 'inspecting or investigations'. The role of NHS England as a commissioner, together with the proximity of NHS England local teams and their capacity to support, meant contractors no longer had access to 'hands-on' facilitation and support by the likes of the dental practice adviser.

There was evidence of regional variation between the services offered and the support given to performers – across the realm of contract issues, financial issues and patient harm issues.

Deaneries and the British Dental Association also have a role to play in providing support at a local level and could be more involved in the future. Discussion also questioned whether opportunities existed for Local Dental Committees to play a supportive role at local level.

These suggestions need to be explored, in the context of the financial constraints. Money spent on support is money not spent on frontline patient care. This could help local systems stop problems before they happen.

There is a clear gap within the system in terms of framework of support for the profession and a regime for quality improvement. The search for a future solution to this issue needs to go wider than the regulatory bodies.

Area for improvement

Define the system and process for quality improvement in the dental sector and the role of key stakeholders in improvement. **This will happen by October 2016.**

6. Improved communication with providers

Providers told us that the communications they received from organisations comprising the Board felt piecemeal and that it seemed to be reactive instead of proactive.

We need to do this better by drawing on existing mechanisms for national and local communication, and developing our relationships with the British Dental Association and Local Dental Committees. There is a need to ensure that commissioners and regulators understand the communication needs of different parts of the dental profession.

In some cases, issues that escalate to the regulators could be prevented through more effective communication of the expected standards, and tools and resources provided so that dental providers could self-assess their service. This would enable the development of a risk-based approach to regulation by concentrating on the small percentage of higher risk practices that require the full focus of regulation.

Clear, consistent and joined-up communication from all the organisations involved in the dental system would enable dental providers to understand the expected standards on all aspects of delivering dental services – whether private or NHS – and could also give the support they need to achieve those standards.

Area for improvement

Develop a system and process for proactive for regular joined up conversation across the sector, supported by a clear communication plan. **This will be done by July 2016.**

7. Improved communication with the public

GDC, NHS England, and CQC all have statutory roles that place patients at the heart of the system of regulation and commissioning. Yet we recognise that there is still some work to do in ensuring the patient voice is heard.

The regulatory and commissioning framework have to meet the diverse needs of the population we service, the public has a view on the quality of service and the experience of receiving treatment. If a member of the public is not sure about that experience or the funding mechanism for treatment, they may not be comfortable approaching their dental professional. Where local Healthwatch receive concerns from members of the public about aspects of poor quality health and social care, they report these concerns to local commissioners and inform Healthwatch England.

Situated in all 152 local authority areas across England, the Healthwatch network has the ability to reach out to every community in the country. Over the last two years, a significant number of these local Healthwatch have been telling Healthwatch England about local difficulties in being able to access NHS dentists, lack of physical access for disabled people, concerns about quality of treatment received and about charging issues. Healthwatch England has used its statutory powers to raise these concerns with NHS England and the Department of Health, and will continue to do so as future problem areas emerge.

In particular, Healthwatch England has identified a need for clear plain English communications, which would enable people understand how best to take care of their teeth in order to reduce the need for dental intervention and extend the frequency between dental visits. Where a visit to a dentist is necessary, good information would allow people to make informed choices about accessing different dental care treatments, the standards of care they can expect to receive and associated costs. As part of the approach to developing the new inspection model, CQC commissioned a piece of qualitative research to provide a clear understanding of what the public and service users think 'good' and 'outstanding' dental services look like. The key findings related to communication and trust, personalised care

provided by friendly, careful and considerate staff. We know from the *Which?* dental campaign (*Which*, 2015) that patients experience issues around dental costs, price lists not being prominently displayed, and patients not being given information on NHS/private alternatives.

We need to make it easier for all patients to have a voice and consider how we reflect the diverse needs of the population in developing the system of dental regulation.

Area for improvement

Develop a proactive and regular approach to keeping patients informed and involved in the quality of dental services. **This will be done by October 2016.**

The way forward

Our work through the first year of the Board's life has looked at the role of regulation through the lens of helping to encourage improvement, holding providers to account, and providing clear information to the public on dental standards.

The GDC research concluded, and we have found through our work that:

“This background to the many bodies involved in regulating dentists, the policy and practice documents available, and the ambiguity of where roles begin and end suggests that the overall job of managing the performance of dentists and the communication and data flow between bodies is a complex one.”

The Board has found a compelling case for change and members are committed to working together on these areas for improvement over the next 12-18 months.

In this report we set out short and medium term actions to tackle issues identified and, whilst we are clear that these areas need addressing, we will continue to test whether these are the right issues and whether they capture the risks. More fundamental change may well be necessary in the longer term.

There are undoubtedly efficiencies to be achieved through a whole system approach to regulating dental services and hopefully the clear identification of the issues and the corresponding areas for improvement set out in this report will start to address those.

We have already posed some of these questions to our stakeholders and it is probably a fair reflection to say that there is divided opinion on how radical and far reaching any long-term change should be. These questions include:

- Should there be fundamental change to professional and system regulation?
- Do we need to change legislation to tackle over-regulation?
- Is regulation the most effective use of resources?
- Should there be a single set of standards?
- What is the role of self-regulation and performance management?
- What is the level of risk?

The current picture of dental regulation is perhaps a reflection of the proliferation (of regulation) that the Professional Standards Authority describes in its report although there are of course some obvious differences. One of the most significant is that dentistry doesn't often feature within the wider political debate about the healthcare system and the nuances aren't necessarily captured between professional and system regulation.

Most importantly, this is an opportunity for reflecting and learning across the system.

We suggest that the features of any future regulatory system should:

- Recognise the diverse needs of the population and assure the safety of all people using services and the quality of treatment they receive.
- Promote and improve quality.
- Ensure transparency and enable choice..
- Ensure that public funds are used effectively
 - By dental professionals
 - By the regulators
 - Duplication minimised
 - Resource focused on the providers/individuals most at risk of providing poor care
- Have a measurable impact on quality.
- Be flexible and adaptable to changing context.

This report sets the basis for important system-wide change, with a commitment from the Care Quality Commission, the General Dental Council, NHS England and the Department of Health and Chief Dental Officer to make this happen. We welcome your support in implementing the areas for improvement set out in this report and your continued engagement in designing the future model.

Appendix A: Regulation of Dental Services Programme Board Terms of Reference

1. Background and programme context

The General Dental Council (the professional regulator); Care Quality Commission (the systems regulator); NHS England (the commissioner of NHS dental care services, which also holds a list of suitable performers); NHS Business Services Authority (a special health authority of the NHS that pays dentists and protects the NHS from fraud); Healthwatch England (national consumer champion in health and care) and the Department of Health 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.

2. Purpose

To review the approach to dental regulation across England and assess the effectiveness of current arrangements to determine an effective model for regulation for the future. The scope will predominantly be primary care, but will be mindful about implications for secondary care and responsibilities across the system including for care pathways. Specific outcomes:

1. Identify roles and responsibilities.
2. Determine the effectiveness of current approaches.
3. Assess consumer and stakeholder views of dental services across England.
4. Develop proposals for alternative model(s) for performance management, inspection and regulation.
5. Option appraisals and business case.
6. Effective information sharing.
7. Communication plan.

3. Membership

Janet Williamson – Deputy Chief Inspector Primary Medical Services Central Region (Chair), CQC

Barry Cockcroft – Chief Dental Officer, NHS England (Sara Hurley from July 2015)

Carole Doble – Head of Dental Services, NHS Business Services Authority

David Geddes – Head of Primary Care Commissioning, NHS England

Amanda Hutchinson – Head of Primary Care and Community Services Policy, CQC

Peter Howitt – Deputy Director, Dental and Eye Care Services, Department of Health

Janine Maher – Communications Manager, CQC

Debbie Mead & Sam Banga – Heads of Inspection, Dentistry, CQC

John Milne – Senior National Dental Adviser, CQC

Carol Reece – Senior Programme Lead (Dental/Community Pharmacy/Optical),
Primary Care Commissioning, NHS England

Claire Robbie – Regulatory Policy Manager, CQC

Susan Robinson – Head of Development, Healthwatch England (Jacob Lant, Head of
Policy and Partnerships, from November 2015)

David Rowland – Head of Corporate Policy, GDC (Evelynne Gilvarry, CEO, from July
2015)

4. Quorum and decision-making

The quorum for transaction of business shall be representation from four out of the
six organisations.

Decision-making will be inclusive as far as possible and timescales will be taken into
account.

5. Frequency of meetings

12 month duration for meetings occurring:

September, November 2014

January, March, May, July 2015 and report in September 2015

6. Governance arrangements

Members will report to their respective Boards in the following ways:

- **NHS England**
Reports to the Primary Care Oversight Group (PCOG). PCOG reports to the
Directly Commissioned Services Committee (DCSC) and DCSC are a sub-
committee of the NHS England Board.
- **GDC**
Governed by the GDC Council which meets every six weeks.
- **NHSBSA**
Reports to the NHSBSA Board which meets eight times a year.
- **DH**
Reports to Dan Poulter and other Ministers.
- **CQC**
Reports to the PMS Monthly Performance Group meeting and the PMS Senior
Leadership Team which convenes weekly. Additionally Professor Steve Field will
provide regular updates to the Executive Team.

7. Secretariat

The agenda for each meeting will be circulated in advance together with any supporting papers, and will be distributed by the Chair. Any items to be placed on the agenda are to be sent to the Chair ahead of the meeting and accompanied by all relevant background papers.

The Chair will provide support to record notes and action points of the Regulation of Dental Services Programme Board meetings, including the recording of names of those present and in attendance. Notes and action points shall be circulated promptly to all members by the Chair. These will also be accessible from the relevant folder on the shared drive.

Appendix B: Roles and responsibilities of member organisations

Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England.

Our purpose is to 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 is to 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.

Since April 2015, we regulate primary care dental services under our new inspection approach. If we find that a service isn't meeting fundamental standards, we take action to make sure it improves. We have a range of powers that we can use.

Department of Health

The Department of Health helps people to live better for longer. We lead, shape and fund health and care in England, making sure people have the support, care and treatment they need, with the compassion, respect and dignity they deserve.

General Dental Council

The General Dental Council is the organisation that regulates dentists and dental care professionals in the United Kingdom:

- Clinical dental technicians
- Dental hygienists
- Dental nurses
- Dental technicians
- Dental therapists
- Orthodontic therapists.

NHS England

- NHS England leads the National Health Service (NHS) in England. We set the priorities and direction of the NHS and encourage and inform the national debate to improve health and care.
- We want everyone to have greater control of their health and their wellbeing, and to be supported to live longer, healthier lives by high quality health and care services that are compassionate, inclusive and constantly-improving.

- NHS England shares out more than £100 billion in funds and holds organisations to account for spending this money effectively for patients and efficiently for the tax payer.
- A lot of the work we do involves the [commissioning of health care services in England](#). We commission the contracts for GPs, pharmacists, and dentists and we support local health services that are led by groups of GPs called Clinical Commissioning Groups (CCGs). CCGs plan and pay for local services such as hospitals and ambulance services.

Healthwatch England

Healthwatch England is the national consumer champion in health and social care. The organisation has statutory powers which can be used to ensure the voice of consumers is heard by those who commission, deliver and regulate health and care services. Where poor quality health and social care is reported, those bodies contacted, must offer a response on the public record.

NHS Business Services Authority

The NHS Business Services Authority is a Special Health Authority and an arms length body of the Department of Health that provides a range of critical central services to NHS organisations, NHS contractors, patients and the public.

Appendix C: References

Works cited

Birmingham, U. o. (2015). Regulation and Performance Management of NHS Primary Care Dentists.

Francis QC, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

Healthwatch England. (March 2015). Primary Care, A review of local healthwatch reports.

Which. (2015). Retrieved from <http://www.which.co.uk/campaigns/dental-treatment-costs/>

Healthwatch England reports

Local Healthwatch Investigate: Access to Primary Care (March 2015).

Every Complaint Matters: A seven-point plan for the NHS and social care

Suffering in Silence (October 2014).

Local Healthwatch reports:

- Healthwatch Barnet: Dentistry in Barnet.
- Healthwatch Barking & Dagenham: Children & Young People.
- Healthwatch Bedford: Visiting a Dentist can Save Your Life.
- Healthwatch Blackburn and Darwen: *Giving Healthwatch Nice Teeth* (developing toolkit), Report in partnership with Blackburn College investigating the experience of young residents accessing GP, Dental, and Sexual Health services.
- Healthwatch Bolton: *Accessing NHS Dentistry in Bolton, Oral Health Care in Residential Care Homes*.
- Healthwatch Bristol: *NHS Dentists not offering NHS Appointments*.
- Healthwatch Buckinghamshire: Healthwatch Bucks NHS Dentist Report.
- Healthwatch Cambridgeshire: flow chart *How to make a complaint about Health Services – Primary Care/NHS England*.
- Healthwatch Dorset: Primary Care Dental Services in Dorset.
- Healthwatch Ealing : Tell HW Ealing about NHS Dental Services Report (April 2014).
- Healthwatch Hampshire: *The Whole Tooth – study into General Dentistry Services in Hampshire*.
- Healthwatch Isle of Wight: Dental Services Report and dental seminar with NHS England Q&A.
- Healthwatch Kent: Considering project.

- Healthwatch Kirklees: *Tell us about NHS dentists and oral health, Are all dentists in Kirklees registered with the General Dental Council (CDC)? How do I find an NHS dentist in Kirklees?*
- Healthwatch Leeds: *Tell us about NHS dentists and oral health.*
- Healthwatch Leicester: NHS Dentistry in Leicester City.
- Healthwatch Liverpool: Access to NHS Dental Services.
- Healthwatch Newcastle: Young People’s Dental Health Project in Newcastle.
- Healthwatch North Somerset: ‘NHS Dentists’ not offering NHS appointments.
- Healthwatch Northamptonshire: NHS Dentist Complaints.
- Healthwatch Rotherham: Access to Dental Practices.
- Healthwatch West Berkshire: Dental experiences – Live report updates.



Department
of Health



CareQuality
Commission

NHS
England

General
Dental
Council

protecting patients,
regulating the dental team

Regulation of Dental Services Programme Board

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