

Consultation

How CQC regulates:

Primary care dental services

Provider handbook

November 2014

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.

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Foreword

This consultation on how CQC will regulate dental care is really important to me, as 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.

In August 2014, we published a statement, *A fresh start for the regulation and inspection of primary care dental services*. Our statement set out our priorities for developing a new approach for primary care dental services. Our main priority is to ensure that we protect the public from unsafe care by continuing to inspect against the regulations and taking action when we identify concerns.

This consultation on our handbook for primary care dental providers sets out how we intend to do this, and how we will work with our partners.

We have asked a number of specific consultation questions and urge you to respond to these, and on any other issues relating to our proposed inspection approach.

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

Introduction

In this document, we are consulting on our proposed new approach to regulating primary care dental services. This consultation will run from 28 November 2014 to 23 January 2015 – details on [how to respond](#) are at the end of this document.

The detail of the consultation is set out in this draft handbook for providers. The handbook sets out the details of how we propose to regulate and inspect services.

CQC's new approach builds on our 2013 consultation, *A new start*, which proposed radical changes to the way we inspect and regulate all health and social care services. We said that we would tailor our inspection methods to different types of health and care services and described how we would inspect and make judgements against five key questions:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

In August 2014, we published a statement, *A fresh start for the regulation and inspection of primary care dental services*. By primary care dental services, we mean those dental services that are predominantly provided by dentists on the 'high street', including services that may visit people in their home if access to a practice is difficult, and any out-of-hours emergency dental services. These services come under the regulatory remit of CQC's Chief Inspector of Primary Medical Services.

Our statement set out our priorities for developing a new approach for primary care dental services:

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

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

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

Priority 4: Adopting a thematic approach to explore particular themes in the quality of dental care.

Our overall priority is to ensure that we protect the public from unsafe care by inspecting against the regulations and taking action where we have concerns. This handbook therefore focuses on priority 3.

For primary care dental services, our approach to inspecting and regulating will assess whether or not a provider is meeting the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. From April 2015, these regulations will be replaced by the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which include the new fundamental standards.

Our inspection reports show our judgement about whether a provider is meeting the regulations. We will structure them in a way that addresses the five key questions that CQC asks of all services: are they safe, effective, caring, responsive to people's needs and well-led?

Unlike other sectors that CQC regulates, we will not be giving a rating to primary care dental services in 2015/16. However, we are interested in people's thoughts about rating in the future.

From December 2014, we will begin to test our new inspection approach in a small number of dental practices. The learning from these early inspections, along with feedback from this consultation, will further develop our approach, which we will implement from April 2015. We will update this handbook ready for the implementation of our new approach from April 2015.

Consistency

We engaged widely with stakeholders and dental providers when developing this draft handbook, and heard that there were some concerns about our ability to be consistent in making judgements. Consistency is one of our core principles that underpins all our work. We have put in place an overall approach across CQC to embed consistency in everything we do. The key elements of this are:

- A strong and agreed core purpose for CQC.
- A clear statement of our role in achieving that purpose.
- Consistent systems and processes to underpin all our work.
- High-quality and consistent training for our staff.
- Strong and consistent quality assurance processes.

In developing our new approach, we have sought feedback from the public, people who use services, providers and organisations with an interest in our work. We encourage providers to tell patients about our new approach and to get involved in the consultation.

1. Our framework

Our operating model

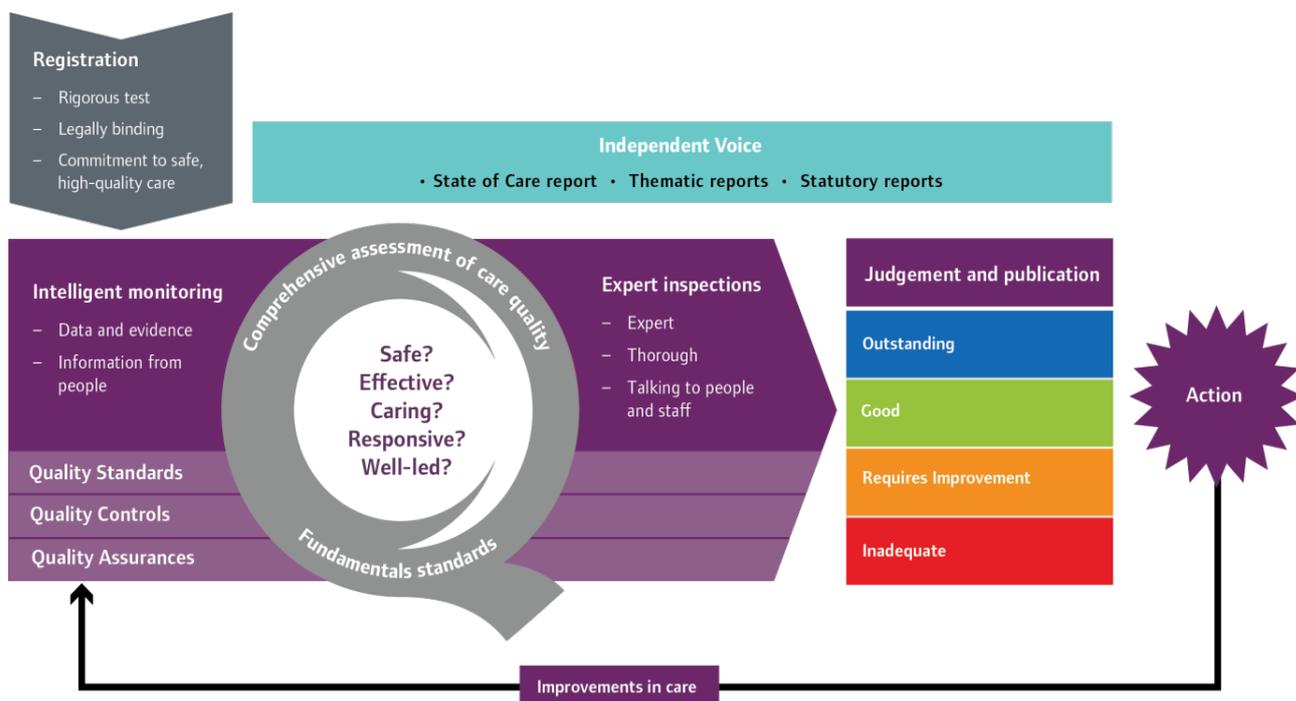
Although CQC inspects and regulates different services in different ways, there are some principles that guide our operating model across all our work. These include:

- Registering those that apply to CQC to provide services (see [section 2](#)).
- Continuous monitoring of local data, shared intelligence and risk assessment.
- Taking action against those who provide services but fail to secure registration before doing so.
- Involving specialist advisors to accompany our dental inspectors where we identify specific concerns.
- Using feedback from people who use services and the public to inform our judgements about services.
- Providing information for the public on our judgements about care quality, including a rating (where applicable) to help people choose services.
- 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. Our enforcement policy sets out how we will do this.
- Using our independent voice, to speak about what we find on behalf of people who use services.

Our model is underpinned by the new fundamental standards, which come into force in April 2015. We will publish guidance to help providers understand how they can meet these fundamental standards.

The diagram on the next page shows an overview of our overall operating model. Although we will not rate dental providers when we start our new approach in 2015/16, we are seeking views as to whether we rate in the future.

Figure 1: CQC's overall operating model



Our framework for dental inspections

Our priority is to ensure that we protect the public from unsafe care by continuing to inspect against the regulations and taking action when we identify concerns.

Therefore our approach to inspecting and regulating primary care dental services will be to assess whether or not a provider is meeting the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, and from 1 April 2015, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which replace them.

The five key questions we ask

To get to the heart of people's experiences of care, the focus of our inspections is on the quality and safety of services, based on the things that matter to people.

Our inspection reports show our judgement of whether a provider is meeting the regulations, and will be structured in a way that addresses the following five key questions that CQC asks of all services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

For all health and social care services, we define these five questions as follows:

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

Inspection prompts and evidence to demonstrate standards are being met

To help inspection teams to make a judgement against the regulations and ensure consistency in our inspection approach, we have developed a set of inspection prompts, which are listed in the [appendix](#). These also include examples of evidence that we would expect to see to demonstrate that standards are being met.

The inspection prompts and examples of evidence are not an exhaustive list, or a 'checklist'. We will consider the amount and depth of evidence that we need to assess whether the standards are being met, and will gather sufficient evidence to be able to reach a robust judgement.

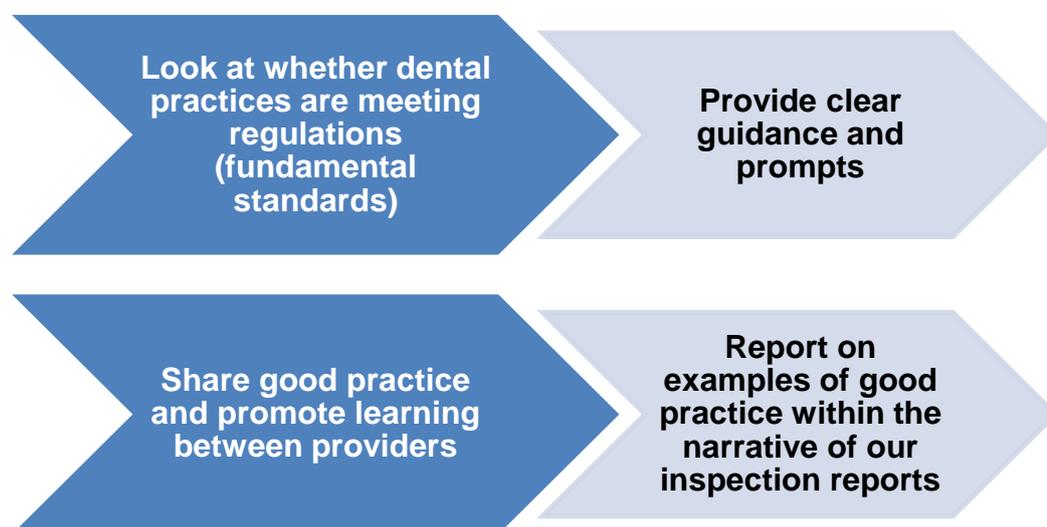
Encouraging improvement

CQC has a role in encouraging services to improve. In the primary care dental sector, one way of doing this is by being clear about our expectations of practices through the guidance that underpins our regulations. Another important way to do this is by sharing good practice. We will develop this aspect of our new approach by working with our stakeholders to develop a clear view and common understanding of what constitutes good practice. We will also work directly with dental providers through our test inspections to identify this.

Good practice means doing more than what the regulations require. When we inspect a practice, as well as gathering evidence against the regulations we will also look for evidence of good practice. We will ask the provider at the start of an inspection to tell us about any good practice measures they have adopted. As well as setting out breaches of regulations in our reports, we

intend to report on examples of good practice that we find. These will be verified by our specialist dental advisor as part of our quality assurance processes to ensure accuracy and consistency, and enable us to build up a portfolio of examples.

Figure 2: How we will encourage improvement



We do not currently intend to rate primary care dental services when we start our new approach in 2015/16, but are seeking views as to whether we rate in the future.

Consultation question:

1. CQC has a role in encouraging services to improve. For primary care dental services we intend to do this by:
 - 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.

Do you think this will help providers to improve?

Consultation question:

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?
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?

Equality and human rights

One of CQC's principles is to promote equality, diversity and human rights. This is a means to an end and not an end in itself. The end is good quality care for all. Respecting diversity, promoting equality and ensuring human rights will mean that everyone using health and social care services receives good quality care.

To put this into practice, we have developed a human rights approach to regulation. This looks at a set of human rights principles in relation to the five key questions CQC asks of services. These principles are: fairness, respect, equality, dignity, autonomy, right to life and rights for staff. We have developed definitions of these principles through public consultation and linked these to the Human Rights Act 1998 and the Equality Act 2010.

People who use services have told us that these principles are very important to them. Using a human rights approach that is based on rights that people hold, rather than what services should deliver, also helps us to look at care from the perspective of people who use services.

Our human rights approach is integrated into our approach to inspecting and regulating primary care dental services, as this is the best method to make sure we promote equality and human rights in our work. We have identified the most important fundamental standards relating to equality and human rights and have integrated the human rights principles into our inspection prompts, inspection methods, learning and development for inspection teams and into our policies around making judgements and enforcement.

Monitoring the use of the Mental Capacity Act

The Mental Capacity Act (2005) is a crucial safeguard for the human rights of people who might (or might be assumed to) lack mental capacity to make decisions, in particular about consenting to proposed care or treatment interventions. The Mental Capacity Act (MCA) provides the essential framework for balancing autonomy and protection when staff are assessing

whether people aged 16 and over have the mental capacity to make specific decisions at the time they need to be made. This refers specifically to the capacity to consent to, or refuse, proposed care or treatment.

The MCA clearly applies where a service works with people who may have cognitive difficulties due to dementia, an acquired brain injury or a learning disability, but providers must also recognise that a person may lack mental capacity for a specific decision at the time it needs to be made for a wide range of reasons, which may be temporary, and know how they should then proceed.

In particular, we will look at how and when mental capacity is assessed and, where people lack mental capacity for a decision, how that decision is made and recorded in compliance with the MCA.

We will look for evidence that restraint, if used to deliver necessary care or treatment, is in the best interests of someone lacking mental capacity, is proportionate and complies with the MCA.

Primary care dental services are unlikely to be responsible for seeking authorisation of a deprivation of liberty. However, staff must be aware that if they are providing care or treatment to a person who is subject to an authorisation for deprivation of liberty, this authorisation does not authorise specific treatment, which must be given using the wider provisions of the Mental Capacity Act. Where it is likely that a person is deprived of their liberty to enable them to receive essential care or treatment, we will look for evidence that efforts have been made to reduce any restriction so that the person is not deprived of their liberty. Where this is not possible we will check that the deprivation of liberty has been authorised as appropriate, by use of the Deprivation of Liberty Safeguards, the Mental Health Act 1983, or by an order of the Court of Protection.

The importance of this is reflected in our inspections. We have a specific prompt about consent, which takes account of the requirements of the Mental Capacity Act and other relevant legislation, such as the Children Acts 1989 and 2004.

Concerns, complaints and whistleblowing

Concerns raised by people using services, those close to them, and staff working in services provide vital information that helps us understand the quality of care. We will gather this information in three main ways:

- Encouraging people who use services and staff to contact us directly through our website and by telephone, and providing opportunities to share concerns with inspectors when they visit a service.
- Asking national and local partners (for example, NHS Area Teams and Healthwatch) to share with us concerns, complaints and whistleblowing information that they hold.
- Requesting information about concerns, complaints and whistleblowing from providers themselves.

We will draw on different sources of evidence to understand how well providers encourage, listen to, respond to and learn from concerns. Evidence sources may include complaints and whistleblowing policies and procedures, reviewing indicators such as a complaints backlog and speaking with people who use services, carers, families and staff.

2. Registration

Before a provider can begin to provide services, they must apply to CQC and secure registration for the regulated activities they intend to deliver. They must satisfy CQC that they will be able to meet a number of registration requirements.

Registration assesses whether all new providers, whether they are organisations, individuals or partnerships, have the capability, capacity, resources and leadership skills to meet relevant legal requirements, and are therefore likely to demonstrate that they will provide people with safe, effective, caring, responsive and high-quality care.

The appendices to this handbook will help registration inspectors to gather and consider comprehensive information about proposed applicants and the services they intend to provide, including where providers are varying their existing registration. They will also help them to make judgements about whether applicants are likely to meet these legal requirements.

Judgements are about, for example, the fitness and suitability of applicants; the skills, qualifications, experience and numbers of key individuals and other staff; the size, layout and design of premises; the quality and likely effectiveness of key policies, systems and procedures; governance and decision-making arrangements; and the extent to which providers and managers understand them and will use them in practice.

These judgements will not stifle innovation or discourage good providers of care services, but ensure that those most likely to provide poor quality services are discouraged and prevented from doing so.

3. How we work with others

Good ongoing relationships with stakeholders are vital to our inspection approach. These relationships allow CQC better access to qualitative as well as quantitative information about services, particularly local evidence about people's experience of care. Local relationships also provide opportunities to identify good practice and to work with others to raise standards.

People who use services

People's experiences of care are vital to our work; they help to inform when, where and what we inspect. We want people to tell us about their care at any time through our website, helpline and social media. We are committed to engaging with the public to encourage people to share their views and experiences with us; this includes people who use services and those close to them, carers and advocates. We do this through raising awareness among the public, working with local Healthwatch organisations, dental care professionals, providers, Experts by Experience and through public events.

Other regulators and oversight bodies

To help focus our inspection activity, we will ask NHS Area Teams (the commissioner of NHS dental services) to share information about providers before an inspection. We want to know if they have recently visited the practice and what the outcome of the visit was – particularly, if they have any areas of concern. During our inspection, if we identify any concerns about the provider that we think require NHS England to take action, we will share this information with the NHS Area Team. If we identify concerns about the fitness to practise of any member of the dental team, we will share these with the General Dental Council.

For primary care dental services that do not have an NHS contract, we are working with our partners to identify what information we may request before an inspection, and who to request this from.

Local organisations

CQC has a statutory duty to have regard to the views of local Healthwatch organisations as part of our wider statutory responsibility to involve people who use services in our work. Each local Healthwatch organisation acts as a voice for any member of the public in its area who wants to influence the commissioning, provision or delivery of care services. As part of our inspection planning, we will write to local Healthwatch organisations and local overview and scrutiny committees to ask them to share with us any issues or concerns they wish to raise about individual practices. The information they provide will help direct the focus of our inspection.

Working with providers

Each registered location of a primary care dental practice will have a member of CQC's inspection staff as their 'relationship owner'. Their role will include reviewing any information received from or about the provider obtained from a number of sources and stakeholders. They will be supported by our intelligence teams who may analyse some of the information.

Our approach to inspection includes continuous monitoring of local data and intelligence and risk assessment. In our signposting statement, *A fresh start*, we committed to making better use of shared intelligence and to take a collaborative approach with our partners to monitor dental care standards. This work is being led by the dental programme board, referred to in our signposting statement as the Tripartite Programme Board on the future of dental regulation in England.

Service providers also routinely gather and use information from people who use services, carers and other representatives. We will make greater use of this information, including information about the number and types of complaints that people make about their care and how these are handled.

Working with corporate providers

CQC defines any provider operating more than 20 locations as a 'corporate provider'. This can include smaller providers where necessary, based on individual circumstances.

Corporate providers in England operate services across all sectors and the majority provide adult social care services. One of CQC's Deputy Chief Inspectors of Adult Social Care has the lead responsibility for CQC's strategy on working with corporate providers.

We are developing our approach across all sectors about how we maintain oversight of the quality and risk profiles of corporate providers. As part of this work, we are developing criteria on responsibility for the relationship management role with each corporate provider. The relationship manager may be from our central Corporate Provider Team or from one of our operational regions. Size, complexity and national interest are taken into account in deciding who should hold the relationship. The relationship manager will hold regular meetings with the provider to exchange information and discuss the organisation's performance. There is no set frequency for these meetings.

4. Inspection

All primary care dental providers registered with CQC (approximately 10,000 practices) must meet the regulations. From April 2015 to March 2016, we intend to inspect 10% of this number, using random and risk-based inspections as well as inspecting in response to concerns.

Our inspections are at the heart of our regulatory model and are focused on the things that matter to people. We will look at how services are provided for all the population including children and young people, adults and people whose experiences may make them vulnerable.

Within our new approach we have two types of inspection:

Type of inspection	Description
Comprehensive Usually scheduled in advance, draws upon a range of data and information to inform scheduling	<ul style="list-style-type: none">• Takes a good look at a service, encompassing all the regulations applicable to primary care dentistry.• Addresses all five key questions CQC asks of services (safe, effective, caring, responsive, well-led).• Usually takes one day at the practice.• May not always include a specialist advisor.• Usually announced two weeks before the inspection.
Focused Could be short notice responding to concerns	<ul style="list-style-type: none">• Follow-up to a previous inspection, or to respond to a particular issue or concern.• Does not look at all the regulations.• Will not address all five key questions CQC asks of services (safe, effective, caring, responsive, well-led)• Team composition and size will depend on the concerns.• May be conducted in partnership with one of our partners i.e. NHS England.• May be unannounced.

We are considering how we inspect corporate providers and will test this throughout 2015.

Consultation questions:

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?
5. For the practices that we don't inspect, how do you suggest we monitor 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.

5. Planning the inspection

To make the most of the time that we are on site for an inspection, we must make sure we have the right information to help us focus on what matters most to people. This will influence what we look at, who we will talk to and how we will configure our team. The information we gather during this time before the inspection is also used as evidence when we make our judgements about the standards.

As described in [section 3](#), we will analyse data from a range of sources, including information from people who use services, information from other stakeholders and information sent to us by providers.

Gathering people's views in advance of our inspections

A key principle of our approach to inspecting is to seek out and listen to the experiences of the public, people who use services and those close to them, including the views of people who are in vulnerable circumstances or who are less likely to be heard. The purpose of this is to better understand the issues that are of most concern to people to guide our inspection.

In the weeks leading up to an inspection, we gather people's experiences of care through:

- Discussions with local Healthwatch and local overview and scrutiny committees.
- Publicising our inspections through a range of channels such as displaying information in the dental practice and asking the provider to let people know that we will be inspecting and to share their experiences with us.

We are continuing to explore the best ways to gather the views of people who use services in advance of our inspections.

Gathering information from the provider

Before we start the inspection, we will write to practices to ask them for some information. Practices will have five working days to respond to our request. We will make clear what information to send, where to send it and who to contact with any queries or questions.

The information we will request is likely to include:

- An up-to-date statement of purpose
- Information about complaints and compliments.

Gathering information from stakeholders

We will write to NHS Area Teams, local Healthwatch organisations and overview and scrutiny committees to ask for information. We may also meet with the NHS Area Team.

Consultation questions:

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?
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?
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?

The inspection team

We are anticipating that most of our inspections will be carried out by a single CQC inspector on a single day. However, to ensure that we gather sufficient and robust evidence to support our judgements, in certain circumstances an inspection would be supported by any or all of the following:

- A larger inspection team.
- Including team members with specific skills.
- Spending more time in the service.

Circumstances that may indicate the need for any of the above include:

- The complexity of a service.
- Increased levels of risk to patient safety.
- Conflicting information about the experiences of people using the service.

Inspection teams may also include Experts by Experience. Experts by Experience are people who have a unique experience of using a particular type of service or who care for someone who uses a service we regulate. For example, in primary care dental inspections, we may involve an Expert by Experience if we need to talk to people whose circumstances make them vulnerable, or people with complex needs that may make access more difficult. Their main role is to talk to people who use services and tell us what they say. Many people find it easier to talk to an Expert by Experience rather than an inspector. Experts by Experience can also talk to carers and staff.

Experts by Experience are recruited and supported to take part in our work through a number of support organisations. The support organisations also carry out the relevant Disclosure and Barring Service checks. Experts by Experience are trained to carry out their role, and their performance is monitored on an ongoing basis. We match their experience to the services that are being inspected. There is further information about Experts by Experience on our website <http://www.cqc.org.uk/content/involving-people-who-use-services>.

Consultation question:

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?

Announcing the inspections

Inspections are usually announced. We feel that this is the most appropriate way to make sure our inspections do not disrupt the care provided to people.

When we announce inspections, we will give two weeks' notice to providers. The inspector will phone the practice to announce the inspection, which will then be followed up in a letter. After announcing the inspection and throughout the inspection process, the lead inspector and inspection planner will support and communicate with the dental practice by letter, email and telephone to help them prepare for the day and know what to expect.

Unannounced inspections

We may also carry out unannounced inspections, for example if we have concerns about a practice or if we are responding to a particular issue or concern. This may be something identified at a previous inspection that we are following up or new information.

At the start of these visits, the team will meet with the most senior person in charge at the time and will feed back to them at the end of the inspection, particularly if there are any immediate safety concerns.

When we are following up concerns from a previous inspection, we will usually carry out an unannounced focused inspection.

Planning meeting with the NHS England Area Teams

CQC's Heads of Inspection for Dentistry will be the main points of contact with NHS England Area Teams before the inspection period. They will telephone the NHS England Area Team(s) to discuss:

- The scope and purpose of the inspection.
- Who will be involved from CQC.
- Which practices we propose to inspect.
- How the inspections will be carried out, including our relevant powers.
- How we will communicate our findings from our inspections to the NHS England Area Team.

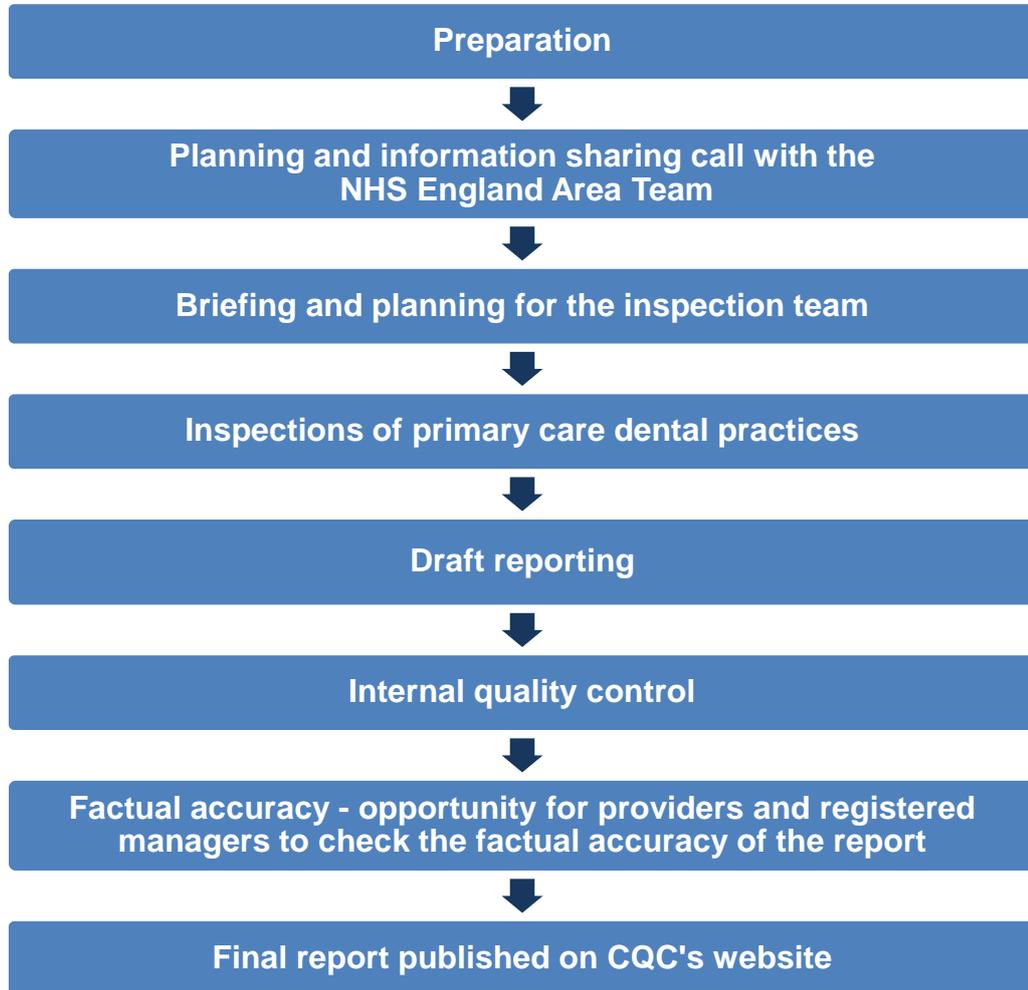
We will then follow up with a letter asking the NHS England Area Team to provide information about recent contract visits and areas of concern. The Heads of Inspection for Dentistry, along with the NHS Area Team, will determine if they need a face-to-face meeting to discuss the information supplied before the inspection.

Where appropriate, we use existing structures and meetings to hold these discussions.

Timetable

Inspections of primary care dental services will go through the following stages:

Figure 2: Stages of a primary care dental inspection



6. Practice visits

Practice visits are a key part of our regulatory framework, giving us an opportunity to talk to people using services, staff and other professionals to find out their experiences. They allow us to observe the physical premises as well as how the practice implements systems and process in delivering the regulated activities. They also enable us to observe care (if appropriate and necessary) and to review people's dental records to see how their needs are identified and managed.

Gathering evidence

The inspection team will use the prompts (see the [appendix](#)), and any concerns identified through the preparation work, to structure their site visit. They collect evidence against the regulations using the methods described below.

Gathering the views of people who use services

We will gather the views of people who use services and those close to them by:

- Speaking individually with people.
- Using comment cards placed in reception areas to gather feedback from people who use services, their family and carers.
- Using posters to advertise the inspection and provide an opportunity to speak to the inspector or any other members of the inspection team. These will be put in areas where people will see them.
- Exploring options for using digital routes for people of all ages to share their experience, through text messaging, social media, such as Twitter, and through mobile apps.
- Using the information gathered from our work looking at complaints and concerns from people who use services.

Where we include Experts by Experience on our inspections, they will talk to people using services at the premises on the day of the inspection.

Gathering the views of staff

The inspection team will speak to staff. On all inspections, we are likely to speak to the following people:

- Dental nurses.
- Individual dentists.
- Practice managers.
- Reception staff.

The inspection team will offer to talk to current and former whistleblowers during the inspection period. This may be during the practice site visit or on the telephone.

Other inspection methods and information gathering

Other ways of gathering evidence may include:

- Reviewing parts of the dental records.
- Reviewing operational policies and supporting documents.
- Observing processes such as the decontamination processes.
- Looking at the premises and facilities.

The start of the visit

At the start of the practice site visit, the inspector will meet with the registered manager. If the registered manager is not available the inspector can meet with another senior member of staff, for example a partner. This introductory session will be short and will explain:

- How CQC regulates primary care dental practices.
- Who the inspection team are.
- The scope and purpose of the inspection, including our relevant powers and the plan for the day.
- How we will escalate any concerns identified during the inspection.
- How we will communicate our findings.

We will ask the practice to share with us any concerns they have identified themselves in their ability to meet the regulations and what they are doing about it. We will also ask them to share with us any good practice that they think goes beyond the requirements of the regulations.

There is no specified format or presentation template media template for this briefing; the provider can choose whichever format suits them. This should take no longer than 30 minutes.

We want providers to be open and share their views with us about where they are providing good care, and what they are doing to improve in those areas they know are not so good.

Continual evaluation

If the inspection is being carried out by a team, the lead inspector will review the emerging findings with the team throughout the day. This keeps the team up to date with all issues and enables them to shift the focus of the inspection if they identify new areas of concern. It also enables the team to identify any further evidence or facts that might still be needed.

Feedback on the visit

At the end of the inspection visit, the inspector will provide feedback to the registered manager or most senior person in charge as agreed at the start of the inspection. This is to give high level initial feedback only, illustrated with some examples.

The meeting will cover:

- Thanking the service for their support and contribution.
- Explaining the findings to date, but noting that further analysis of the evidence will be needed before final judgements can be reached on all the issues.
- Any issues that were escalated during the visit or that require immediate action.
- Any plans for follow-up or additional visits (unless they are unannounced).
- Explaining how we will make judgements against the regulations.
- Whether we need additional evidence or are likely to seek further specialist advice.
- Explaining the next steps, including factual accuracy checking of the draft report, final report sign-off and publication.
- Answering any questions from the practice.

7. Focused inspection

Focused inspections do not usually look at all the regulations; they focus on the areas indicated by the information that triggers the focused inspection.

Areas of concern

We will undertake a focused inspection when we are following up on areas of concern including:

- Concerns that were originally identified during a comprehensive inspection.
- Concerns that have been raised with us through other sources, such as information from our stakeholders, members of the public, staff.

Change of service provider

We may undertake a focused inspection, depending on the level of risk to patient and safety and quality of care, when there is a change in the legal entity of the service provider, such as sale, merger or an acquisition of a service.

The focused inspection process

Although they are smaller in scope, focused inspections broadly follow the same process as a comprehensive inspection. The reason for the inspection determines many aspects, such as the scale of the inspection, when to visit, what evidence needs to be gathered, the size of the team and which specialist advisers to involve. These visits may be announced or unannounced, depending on the focus of the inspection.

As a focused inspection is not an inspection of the whole of a provider, we will not necessarily address all the five key questions; safe, effective, caring, responsive and well-led.

When a focused inspection identifies significant concerns, it may trigger a comprehensive inspection.

8. Making a judgement

Our statutory objective is to protect and promote the health, safety and welfare of people who use health and social care services.

When making our judgement to determine whether a provider is meeting the regulation, we will consider the weight of each piece of relevant evidence. In some cases, we will need to corroborate our evidence with other sources to support our findings and to enable us to make a robust decision.

Decisions will be derived from all the available corroborated evidence. We will use three main sources of evidence:

1. Information from the ongoing relationship management with the dental practice.
2. Pre-inspection information gathering.
3. Information from the inspection visit.

When we have conflicting evidence, we will consider the weight of each piece of evidence, its source, how robust it is and which is the strongest. We may conclude that we need to seek additional evidence or specialist advice in our assessment against the regulations.

If the provider is not meeting the regulations we have to consider our approach and ensure that our regulatory response is proportionate to the circumstances. Where appropriate, if the provider is able to improve the service on its own and the risks to people who use the service are not immediate, we will expect the provider to make improvements. We will do this as part of our powers under Regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This will be reflected in our inspection report and judgement of the five key questions that CQC asks of services.

We will intervene if people are at risk of harm or providers appear not to be following the regulations. We will start with whatever level of intervention will achieve our purpose of protecting people who use the service, or holding providers and individuals to account, or both.

In addition to our statutory powers, we also work with other regulatory and oversight organisations to ensure that they take action on any concerns that we have identified, where that is more proportionate or likely to be more effective than CQC acting on its own.

9. Reporting, quality control and action planning

Reporting

After each inspection we produce a report on what we found. To do so is a legal obligation under section 61 (3) of the Health and Social Care 2008. The report is drafted in collaboration with members of the inspection team (where applicable) and is written in clear, accessible plain English.

Our reports focus on our findings on whether a provider is meeting the regulations but they will be structured in a way that they address the five key questions CQC asks of services: are services safe, effective, caring, responsive and well-led? In our reports, we clearly set out any evidence about breaches of the regulations.

Quality control

Consistency is one of the core principles of CQC's work. The key elements of this are:

- Consistent systems and processes to underpin all our work.
- High-quality professionally reviewed training for our staff.
- Strong and reliable quality control and assurance processes.

We have made a commitment to strong internal quality control and assurance mechanisms.

Following quality checks, the draft report is sent to the provider for comment in relation to factual accuracy. The report is published following any necessary changes.

Action planning

We expect practices to respond to areas of concern that we have identified and to make the recommended improvements. This is their responsibility and includes developing an action plan to address any concerns raised.

Publication

CQC will publish the inspection reports on our website after the end of the inspection. We encourage dental practices to publish their report, including any action plans, on their own website.

11. Enforcement and actions

Types of action and enforcement (under existing regulations)

Where we have identified concerns, we decide what action is appropriate to take. The action we take is proportionate to the impact or risk of impact that the concern has on the people who use the service and how serious it is. Where the concern is linked to a breach in regulations, we have a wide range of enforcement powers given to us by the Health and Social Care Act 2008.

We use 'Warning Notices' to tell providers that they are not complying with a condition of registration, requirement in the Act or a regulation, or any other legal requirement that we think is relevant.

Our enforcement policy describes our powers in detail and our general approach to using them.

We include in our report any concerns, recommended improvements or enforcement action taken, and expect the provider to take appropriate action.

We follow up any concerns or enforcement action we take. If the necessary changes and improvements are not made, we can escalate our response, gathering further information through a focused inspection. However, we always consider each case on its own merit and we do not rigidly apply the enforcement rules when another action may be more appropriate.

Relationship with the new fundamental standards

The Department of Health is introducing new regulations to replace the current registration requirements. The new regulations, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, called 'fundamental standards', are more focused and clear about the care that people should expect to receive. These regulations will come into force in April 2015. Until that time, we will continue to enforce against the existing regulations.

We will issue guidance to help providers to understand how they can meet the new regulations and, when they do not, what actions CQC will take. Our final handbook will reflect the new regulations.

New regulations: fit and proper person requirement and the duty of candour

Two new regulations, Regulation 5: Fit and proper persons: Directors and Regulation 20: Duty of candour, will apply to primary care dental services from April 2015 subject to Parliamentary process and approval.

The fit and proper person requirement for directors will place a clear duty on health and social care providers to make sure that directors and board

members (or their equivalents) meet criteria set out in the regulation. Organisations retain full responsibility for appointing directors and board members (or their equivalents). However, CQC will be able to intervene where it considers an individual is not a fit and proper person, and place a condition on a provider to remove the director (or equivalent) if there is evidence that they have previously been involved in failures to deliver good quality, safe care.

The duty of candour will apply to all organisations registered with CQC from April 2015. This means that people, and where appropriate their families, must be told openly and honestly when unanticipated things happen, which cause them harm above a pre-determined threshold. They should be given an apology, an explanation, all necessary practical and emotional support, and assurances about their continuity of care. This statutory duty on organisations supplements the existing professional duty of candour on individuals.

Responding to inadequate care

As well as using our enforcement powers, CQC will also work with other regulators and oversight bodies, such as the General Dental Council and NHS England, to ensure action is taken to address concerns that we identify.

Challenging the evidence

We want to ensure that providers can raise legitimate concerns about the way we apply our judgements, and have a fair and open way of resolving them.

Providers can challenge the factual accuracy of reports and make representations about the evidence in Warning Notices. Primary care dental services can challenge our judgements in the following ways.

Factual accuracy check

When a provider receives a copy of the draft report it is invited to provide feedback on the factual accuracy. Providers can challenge the accuracy and completeness of the evidence. Practices have 10 working days to review draft reports for factual accuracy and submit their comments to CQC.

Warning Notice representations

If we serve a Warning Notice, we give registered persons the opportunity to make representations about the matters in the Notice. The content of the Notice will be informed by evidence about the breach that is in the inspection report.

Under our process for factual accuracy checks and Warning Notice representations, unresolved issues can be escalated to managers in CQC who were not involved in the inspection.

Appendix A: Regulation mapping and dental prompts

The prompts for inspectors relate to CQC’s five key questions that we ask of services. The prompts ensure a consistent approach to inspection and judgement against the regulations. For this consultation, we have mapped these to the existing and new regulations. For inspections until April 2015, we will use existing regulations and guidance (the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010) to make judgements, and will gather evidence against these if we need to take regulatory action. Our examples of what we should see to demonstrate that the regulations are being met have been drawn from both the Guidance about compliance with existing regulations and draft guidance on the forthcoming regulations (fundamental standards).

Please note: The inspection prompts and examples of evidence are not an exhaustive list, or a ‘checklist’.

Is the service safe? By safe, we mean that people are protected from abuse and avoidable harm.	
Current regulations: Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – essential standards	From April 2015: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – fundamental standards
<ul style="list-style-type: none"> • Records Regulation 20 • Safeguarding Regulation 11 • Cleanliness and infection control Regulation 12 • Medicines Regulation 13 • Safety and suitability of premises Regulation 15 • Safety and suitability of equipment Regulation 16 • Requirements related to workers Regulation 21 • Supporting workers Regulation 23 	<ul style="list-style-type: none"> • Safe care and treatment Regulation 12 • Safeguarding service users from abuse and improper treatment Regulation 13 • Fit and proper persons employed Regulation 19 • Staffing Regulation 18 • Premises and equipment Regulation 15 • Duty of candour Regulation 20

<ul style="list-style-type: none"> • Staffing Regulation 22 • Quality of service provision Regulation 10 	
Inspection prompts	Examples of what we should see to demonstrate that the regulations are being met (regulations guidance)
<ul style="list-style-type: none"> • What systems, processes and practices are in place to ensure all care and treatment is carried out safely? • How is care assessed to prevent unsafe care and treatment? • What systems, processes and practices are in place to protect people from unsafe use of equipment, materials and medication? • What systems, processes and practices are in place to prevent healthcare-associated infections? • How are potential risks to the service and individuals assessed/identified and managed/minimised? • How are lessons learned and improvements made when things go wrong? • What systems, processes and practices are in place to keep people safe and safeguard them from abuse? 	<ul style="list-style-type: none"> • Premises and equipment are clean and kept in accordance with current legislation and guidance i.e. The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance, HTM 01-05 and HTM 04-01. • Equipment is cleaned and/or decontaminated according to manufacturers' instructions, and is cleaned/decontaminated after each use. • There are sufficient quantities of instruments/equipment to cater for each clinical session which takes into account the decontamination process. • Staff demonstrate competency in the use of equipment. • The provider complies with relevant patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Authority (MHRA) and through the Central Alerting System (CAS). • Providers meet the requirement of relevant legislation to ensure that premises and equipment are properly used and maintained i.e. Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER), Sharps regulations 2013, HTM 07-01 (healthcare waste). • There is a clear understanding of RIDDOR and COSHH. • Health and safety risk assessments are regularly carried out. • Care and treatment takes account of published research and guidance i.e. Standards for conscious sedation Royal College of Anaesthetists, Department of Health Standing Committee Guidelines in Conscious Sedation 2003 and Guidelines for Domiciliary care by the British Society for Disability and Oral Health. • Arrangements are in place to ensure that the provider can take appropriate action in the event of a clinical/medical emergency.

	<ul style="list-style-type: none"> • The provider Identifies and analyses events, incidents, errors and near misses to establish what caused them. • Staff understand the reporting system for raising concerns and feel confident to use it. • There is a zero tolerance approach to abuse. • Staff know how to identify, report and respond to suspected or actual abuse. • The provider and staff work within the ethos of the Mental Capacity Act 2005 when working with people who lack capacity to make decisions. • There are sufficient numbers of suitably qualified staff, and the provider considers how the practice uses the skills of other dental professionals. • There is openness and transparency when things go wrong. If a person's treatment goes wrong they receive a full explanation of what went wrong and why. After April 2015.
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<h2 style="margin: 0;">Is the service effective?</h2> <p style="margin: 0; font-size: 0.9em;">By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.</p>	
Current regulations: Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – essential standards	From April 2015: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – fundamental standards
<ul style="list-style-type: none"> • Co-operating with other providers Regulation 24 • Care and welfare Regulation 9 • Staffing Regulation 22 • Consent Regulation 18 	<ul style="list-style-type: none"> • Person centred care Regulation 9 • Duty of candour Regulation 20 • Consent Regulation 11 • Staffing Regulation 18

Inspection prompts	Examples of what we should see to demonstrate that the regulations are being met (regulations guidance)
<ul style="list-style-type: none"> • How are patients involved in decisions about their treatment? • How does the practice obtain valid consent? • How does the provider assess patients' needs so care and treatment can be delivered in line with current legislation, standards and guidance? • What arrangements are in place for referral to other health professionals ensuring the quality and continuity of care for patients? • Do staff have the appropriate qualifications, skills, knowledge and competence to enable the effective delivery of care and treatment? 	<ul style="list-style-type: none"> • There is evidence of a comprehensive assessment to establish individual needs. This should include an up-to-date medical history, explanation of the presenting complaint or purpose of the appointment, a clinical assessment and treatment options. • The provider has made information and support available to help people understand the care and treatment options. • Staff demonstrate that consent is on-going and can be withdrawn at any time. • Staff understand when people may require more support than others in obtaining consent. • Assessments reflect current legislation and guidance such as NICE, Faculty of General Dental Practice (FGDP) Selection Criteria for Dental Radiography, Standards for conscious sedation, Standing Committee Guidelines in Conscious Sedation 2003 and Guidelines for Domiciliary care by the British Society for Disability and Oral Health, FGDP Clinical Examination and Record-Keeping: Good Practice Guidelines, GDC standards for the Dental Team, Department of Health Delivering Better Oral Health toolkit. • Staff are supported to undertake training, learning and development to enable them to fulfil their role.

Is the service caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Current regulations:

Health and Social Care Act 2008 (Regulated Activities)
Regulations 2010 – essential standards

- Consent **Regulation 18**
- Respecting and involving **Regulation 17**

From April 2015:

Health and Social Care Act 2008 (Regulated Activities)
Regulations 2014 – fundamental standards

- Consent **Regulation 11**
- Dignity and respect **Regulation 10**

Inspection prompts

- Are patients treated with kindness, dignity, respect and compassion while they receive care and treatment?
- How are people and those close to them involved as partners in their care?
- How does the practice promote equality diversity and human rights?

Examples of what we should see to demonstrate that the regulations are being met (regulations guidance)

- People report that they are treated with dignity and respect at all times. The environment is conducive to supporting people's privacy.
- People report that staff respond to pain, distress and discomfort in a timely and appropriate way.
- Treatment is fully explained, and people report they are given enough time to think about their consent to care and treatment.
- Privacy is maintained at all times.
- Confidentiality or information disclosure is taken into account in assessing individual circumstances.
- People report that they felt the dentist or other members of the dental team listened to them.
- Staff recognise and respect people's diversity, values and human rights.

Is the service responsive?

By responsive, we mean that services are organised so that they meet people's needs

Current regulations:

Health and Social Care Act 2008 (Regulated Activities)
Regulations 2010 – essential standards

- Complaints **Regulation 19**
- Respecting and involving **Regulation 17**

From April 2015:

Health and Social Care Act 2008 (Regulated Activities)
Regulations 2014 – fundamental standards

- Complaints **Regulation 16**
- Person centred care **Regulation 9**
- Duty of candour **Regulation 20**

Inspection prompts

- How does the practice listen and learn from people's concerns and complaints to improve the quality of care?
- How are dental services planned and delivered to take account of the needs of different people on the grounds of age, disability, gender, gender identity, race, religion or belief and sexual orientation?
- Are reasonable adjustments made so that people with a disability can access and use the service on an equal basis to others?

Examples of what we should see to demonstrate that the regulations are being met (regulations guidance)

- There is a complaints system in place, which is accessible, understood and well-publicised and reflects the principles of good complaint handling.
- Patients know the steps they can take if they are not satisfied with the findings or outcome once the complaint has been responded to.
- Providers take timely and appropriate action in response to any failures identified.
- Providers make reasonable adjustments such as to the environment, choice of dentist, or treatment options to enable patients to receive care and treatment.
- There is openness and transparency about reporting of errors and incidents.
- There is evidence that the provider gathers the views of patients in the running of the service.
- All reasonable efforts/adjustments are made to enable patients to receive their care or treatment.

<ul style="list-style-type: none"> • Do people have timely access to urgent treatment? • What action is taken to minimise the time people have to wait for treatment or care? • How does the dental practice engage with people who are in vulnerable circumstances and what actions are taken to remove barriers when people find it hard to access or use services? 	<ul style="list-style-type: none"> • The provider makes patients aware of how they can access emergency treatment, including out of normal hours. • A clear plan of treatment should be developed to enable appropriate planning, including appointments. • Care and treatment is designed to ensure it meets all of the patient's needs. • Patients have access to and receive information in the manner that best suits them and that they can understand.
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Is the service well-led?

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality, person-centred care, supports learning and innovation, and promotes an open and fair culture.

<p>Current regulations:</p> <p>Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – essential standards</p>	<p>From April 2015:</p> <p>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – fundamental standards</p>
<ul style="list-style-type: none"> • Supporting workers Regulation 23 • Staffing Regulation 22 • Complaints Regulation 19 • Records Regulation 20 • Quality of service provision Regulation 10 	<ul style="list-style-type: none"> • Complaints Regulation 16 • Good governance Regulation 17 • Duty of candour Regulation 20 • Staffing Regulation 18 • Fit and proper person requirement directors Regulation 5

Inspection prompts	Examples of what we should see to demonstrate that the regulations are being met (regulations guidance)
<ul style="list-style-type: none"> Do the governance arrangements ensure that responsibilities are clear, quality and performance are regularly considered and risks are identified, understood and managed? 	<ul style="list-style-type: none"> Staff are supported and managed at all times and are clear about their lines of accountability. Where required, there is a registered manager in post who understands their responsibilities and is supported. Staff are supported to meet their professional standards and follow their professional code of conduct. Patients' care and treatment records are complete, legible and accurate, and are kept secure. Records relating to employed staff should include information relevant to them being employed in their role.
<ul style="list-style-type: none"> How does the leadership and culture reflect vision and values, encourage openness and transparency and promote delivery of high quality care? 	<ul style="list-style-type: none"> The provider has systems, policies and procedures in place to support a culture of openness and transparency and all staff follow these. Staff understand how to confidentially raise concerns about risks to people, poor practice and adverse events, and they feel confident to do so.
<ul style="list-style-type: none"> How is quality assurance used to drive continuous improvement? 	<ul style="list-style-type: none"> There is an effective approach for identifying where quality and/or safety is being compromised and steps are taken in response to issues. These include audits of radiological images, clinical notes, Legionnaires' disease, infection prevention and risks, incidents and near misses and autoclave checks. The provider has systems in place to support communication about the quality and safety of services and what actions have been taken as a result of concerns, complaints and compliments. Information about the quality of care and treatment is actively gathered from a range of sources.

- How does the practice engage, seek and act on feedback from people who use the service, public and staff?

- Providers have processes in place to actively seek the views of patients and those close to them, and should be able to provide evidence of how they take these views into account in any related decisions.

Consultation question:

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

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?

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?

How to respond to this consultation

You can respond to our consultation in the following ways. Please send us your views and comments by **Friday 23 January 2015**.

Online

Use our **online form**

You can also find the form and more information at:

www.cqc.org.uk/consultation-dental-independenthealthcare-ambulance

By email

Email your response to: CQCchanges.tellus@cqc.org.uk

By post

Write to us at:

CQC consultation: How we inspect, regulate and rate
CQC National Customer Service Centre
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

On Twitter

Use **#tellecqc** for your feedback and mention [@carequalitycomm](https://twitter.com/carequalitycomm)

Consultation questions

1. CQC has a role in encouraging services to improve. For primary care dental services we intend to do this by:
 - 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.

Do you think this will help providers to improve?

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?
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?
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?
5. For the practices that we don't inspect, how do you suggest we monitor 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.
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?
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?
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?

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?
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](#).)
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?
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?
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.

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