

Response to our consultation on how we regulate

Primary care dental, ambulance, and independent acute healthcare services

March 2015

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

Our purpose

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

Our role

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

Our values

- Excellence – being a high-performing organisation
- Caring – treating everyone with dignity and respect
- Integrity – doing the right thing
- Teamwork – learning from each other to be the best we can

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Section 1: Our consultation

Introduction

From April to June 2014, CQC consulted on our 'provider handbooks' that set out our proposals for inspecting and rating providers of health and adult social care services. This consultation on our new approach built on our 2013 consultation, *A new start*, which proposed radical changes to the way we inspect and regulate health and adult social care.

From 28 November 2014 to 23 January 2015, we consulted on our proposed new approach to regulating, inspecting and rating (where appropriate):

- NHS and independent ambulance services
- Primary care dental services
- Independent acute healthcare services.

This report sets out the responses we received to the consultation on the proposed provider handbooks for these three types of provider.

The consultation documents (the provider handbooks) outlined how we will carry out inspections, which includes gathering information and engaging with people who use services and the public beforehand, the inspection visit itself, and our process for awarding a rating, where appropriate.

The three provider handbooks consulted on our proposals (where appropriate) for:

- What we look at on an inspection.
- How we judge what good care looks like.
- How we will, or won't, rate services to help members of the public choose a care provider and encourage improvement.
- How we use information to help us decide when and where we inspect.

We developed the proposals outlined in these consultation documents over the previous year in cooperation with the public, providers, our staff, and organisations with an interest in our work.

During this period, we also tested our new style inspections in NHS ambulance trusts, independent acute healthcare and primary care dental service providers.

The final handbooks, developed using the feedback from the consultation and our pilot inspections, will be published in March 2015. The changes will come into effect in April 2015.

The main themes of our actions following the feedback on our proposed approach are:

- Introducing new ways to inspect services, with chief inspectors and more specialist teams that include members of the public and experts.
- Developing a new system of Intelligent Monitoring to help us decide when, where and what to inspect.
- Listening to people's experiences of care and using the best information across our monitoring system.
- Making judgements based around the five key questions we ask of all services:
 - Are they safe?
 - Are they effective?
 - Are they caring?
 - Are they responsive to people's needs?
 - Are they well-led?
- Basing ratings around the five key questions for ambulance and independent acute healthcare services.
- Not rating primary care dental services. We proposed that we wouldn't rate primary care dental services but we asked you to give us your thoughts about rating them in the future.

Section 2 of this document sets out the changes we are making as a result of the learning and feedback from the consultation.

Section 3 sets out the themes from these consultation responses, the key points from the feedback, feedback from providers and the findings from our inspection methodology testing and our response.

How we engaged and who we heard from

We heard from more than 507 individuals and organisations throughout our consultation.

Responses came through a number of sources, including:

- Online web forms
- Online community websites
- Email and written submissions
- Focus groups
- Social media
- Face-to-face meetings.

We received 25 written submissions from a range of organisations (see appendix A for details), and 178 responses through an online web form.

We also used our regular communications channels to promote the consultation through:

- Newsletters to all registered healthcare providers, the public, local Healthwatch and overview and scrutiny committees.
- Newsletters to all registered providers of health and social care services and frontline care professionals.
- Online communication for providers and professionals (around 8,100 members) and the public (around 2,200 members).
- Our social media accounts – @CareQualityComm (main account with more than 50,000 followers) and @CQCProf (an account targeting providers of services and their staff with more than 3,600 followers).
- A sponsored discussion on Mumsnet.

During the consultation period we engaged with the following provider and healthcare professionals in the following ways:

- 27 November – article in the healthcare provider newsletter on the ambulance and independent acute healthcare providers consultation. Notification of the launch.
- 28 November – email to all ambulance, dental, and independent acute providers to announce the launch of the consultation.
- 28 November – email to ambulance, dental, and independent acute providers advisory groups to announce the launch of the consultation.

- 28 November – news article on the online community for providers and professionals promoting the consultation.
- 28 November – email to online community for providers and professionals.
- 2 December – meeting with the ambulance external advisory group.
- 19 December – article in the healthcare provider newsletter on the ambulance and independent acute healthcare providers consultation.
- 6 January – dental co-production workshop with stakeholders and providers.
- 7 January – meeting with the independent acute healthcare advisory group.
- 19 January – consultation reminder email to ambulance, dental, and independent acute providers advisory groups.
- 19 January – consultation reminder email to the online community for providers and professional members.
- 20 January – reminder of the consultation closing date at a meeting with the dental reference group.

We used the consultation documents (provider handbooks) at events, as well as consulting with providers and professionals through the online community during the consultation period.

We engaged with the public through the following:

- 24 November – promoting the consultation by advertising our Twitter question and answer session on 10 December 2014.
- 28 November – press release to announce the launch of the consultation.
- 28 November – communication to the CQC External Advisory Groups to encourage them to promote the consultation.
- 28 November – communication to public voluntary sector stakeholders to inform them of the consultation launch and request they help with promotion.
- 28 November – article in local Healthwatch bulletin.
- 28 November – communication to SpeakOut network, National Complaints Advocacy and Overview and Scrutiny Committees.
- 28 November – article in the CQC Action Team newsletter.
- 28 November – communication to Experts by Experience support organisations.
- 28 November – communication to the Service User Reference Panel (people detained under the Mental Health Act).
- 28 November – online community news item to announce the launch of the consultation.

- 28 November – article in the CQC public newsletter.
- 28 November – news story on the Mumsnet and Gransnet microsites.
- 12 December – public online community task – asking members of the public what the top five questions to ask on dental inspection should be.
- 12 December – public online community discussion asking ‘what does good ambulance care look like?’.
- 15 December – promotion via the Private Patients Forum.
- 5 January – advertising on Mumsnet and Gransnet.
- 5 January – Mumsnet sponsored thread goes live.
- 6 January – Twitter question and answer session with Ellen Armistead, Deputy Chief Inspector of Hospitals (Community).
- 12 January – reminder email to key voluntary sector partners.
- 12 January – Centre for Public Scrutiny (CfPS) teleconference with councilors.
- 14 January – discussion with the Children and Young People Advisory Group around their experience of ambulance services.

We arranged focus groups with a range of people who are harder to reach due to their circumstances.

The focus groups were organised and facilitated on behalf of CQC by a third party organisation.

The groups included the following:

- Binoh – Othodox Jewish group
- CARES – carers group (Smethwick)
- Disability Equality North West – group for people with disabilities
- Windrush Initiatives – community interest company working with black/multi-heritage communities
- Lesbian and Gay Foundation (Manchester)
- My Life, My Choice – group for people with learning disabilities
- Children and Young People’s Advisory Group
- Black Health Agency – a health and social care charity (Manchester)
- People First Learning Difficulties (Saltash, Cornwall)
- Derbyshire Gypsy and Traveller Group (Matlock)

- Shiloh – Christian charity (Rotherham)
- Sifa Fireside – charity working to tackle homelessness and alcohol misuse (Digbeth, Birmingham)
- Al Hayat Men’s Group (Halifax).

In addition to this, we commissioned an external agency, Quality Health, to conduct qualitative research with the public on ‘What does good care look like’ for ambulance, dental, and independent acute healthcare services.

How we analysed feedback from the consultation

We commissioned Quality Health to support the consultation process. Quality Health has reviewed, analysed and reported on all the feedback collected from the consultation. We have published their full report on our website. This provides analysis of all responses received.

Section 2: Key changes to our new approach

In response to the consultation feedback we received between 28 November 2014 and 23 January 2015, we have made the following key changes, or confirmed the existing proposals, for our new approach.

For ambulance services

- Core services will be weighted equally. This is based on the principle that everyone who receives care and treatment should expect to receive the same good quality care, irrespective of the type of service that they are using.
- We will use the key lines of enquiry (KLOEs) and prompts that have been developed for the ambulance sector as the framework for inspections going forward for NHS ambulance trusts, and in the development of our approach for independent ambulance services.
- We will rate NHS ambulance trusts using the same rating principles applied to other NHS trusts from April 2015.
- We will observe care being provided to people by paramedics and emergency care assistants. This will involve observing emergency ambulance shifts and having the opportunity to speak to staff.
- Following an announced visit, the inspection team will normally carry out further inspection activities unannounced within a 10–15 day period.
- When aggregating ratings, our inspection teams will follow a set of principles to ensure consistent decisions are made.
- We will rate NHS ambulance trusts at core service level, and also rate NHS ambulance trusts at location level rather than area level.
- We will continue to develop our approach for those services we are currently unable to rate, which includes independent ambulance services.
- We will carry out pilot inspections of independent ambulance services and work with providers, stakeholders and the public during 2015 to decide which independent ambulance services it is appropriate to rate, and at what level.
- We will not rate at corporate level (other than for NHS trusts). However, we will be including corporate engagement in our relationship management.
- We want to ensure that services found to be providing inadequate care do not continue to do so; therefore we will introduce special measures.

For primary care dental services

- We will ask if a practice meets the five key questions CQC asks of services; are they safe, effective, caring, responsive and well-led. However, we will not provide ratings.
- We will use the term 'notable practice' rather than 'good practice' as the sector confuses this with clinical good practice or best practice.
- We will be more explicit about our approach to how we identify the 10% of practices to be inspected, particularly the practices which we view as being of greater risk of not meeting the regulations, including the fundamental standards.
- We will make intelligent use of data, evidence and information to monitor services while we develop our approach to intelligent monitoring within the primary care dental sector during 2015.
- We will use a set of proposed criteria to identify the practices we will inspect under the risk based model. These include:
 - Providers who have been registered for more than 18 months and not had an inspection.
 - Providers whom we have concerns about due to whistleblowing, complaints, enforcement activity, for example.
 - Concerns shared by our partners such as the General Dental Council and NHS England.
- Where possible, we will aim to ensure a proportionate sample from across all providers when selecting practices to inspect.
- We will publish a series of myth busters to help clear up some common myths related to how we regulate primary care dentistry. We will also develop 'learning sets' where inspectors can continue to learn about the dental sector.
- We will develop our approach to how we monitor the practices we don't inspect during 2015-16.
- We will continue to use comment cards in practices to capture views before we inspect, and explore other approaches, along with talking to people who use services during our inspections.
- On most occasions our inspectors will be accompanied by a dental specialist advisor. We will use key lines of enquiry (KLOEs) instead of inspection prompts to align further with our operating model.
- We will continue to look at a range of evidence to judge whether a practice meets the regulations, including the fundamental standards. This will include, looking at aspects of the dental records such as treatment plans and medical questionnaires.

For the independent healthcare acute sector

- We have agreed to hold back our testing of the non-hospital independent healthcare sector until we have a better definition of what services will be included in this group. We will engage further with these providers and consult with providers of independent doctor services, such as consultants who are on the UK specialist register at the General Medical Council (GMC) and who may work exclusively in the private sector, or carry out some NHS work, but are not exempt from registration, private GPs, private mobile call out doctors, travel vaccination clinics, slimming clinics. We will do this during the spring/summer.
- We are reviewing the requirements to ask for financial information within the Provider Information Return (PIRs). We will be working with The Private Healthcare Information Network (PHIN) to develop metrics that can be accessed through the central collection of data.
- We will look to develop metrics for independent healthcare providers that could potentially be used for intelligent monitoring purposes. We will be looking at all available data sources to help support inspection of independent single specialties.
- We will review our general inspector training to ensure that our workforce has the appropriate skills and knowledge to undertake inspections within the independent healthcare acute sector.
- For single speciality hospitals, we have already developed and delivered a training programme for one of the single speciality services ahead of the pilot inspection. We will evaluate this training and consider how this model can be adapted for the wider range of independent healthcare inspections.
- We will undertake further work to determine how established and recognised accreditation schemes can support our intelligence led view of services.
- We will continue to test our approach to single speciality providers over the next six months. Where possible we will group single specialities together, however, this will be dependent on the number of registered locations in each single speciality group.
- We have decided that hair transplantation services should move to the non-hospital acute group.
- We will continue to review and improve on our approach to engagement with patients and the public for all sectors to improve our understanding of the patient experience.
- We will continue to develop our approach to those services that we are currently unable to rate.

- We will continue to develop our understanding of the sectors, their diversity and how they align with CQC directorates and undertake co-production and engagement with both the public and providers.
- We currently do not plan to rate at corporate level. However, we will continue to develop our approach at this level during 2015.

Section 3: What you told us and our response

Ambulance services

33 respondents replied to the 11 consultation questions:

- 30 responded via the online webform.
- Three responded via a written submission.
- Four respondents submitted general written comments about the consultation via email and letter.
- Eight written submissions addressing the consultation questions were received from stakeholders, which included:
 - an ambulance service provider
 - a borough council
 - a clinical commissioning group
 - a commissioning support unit
 - a professional body
 - a patient representative body
 - an anonymous respondent
 - a national disability forum response to the equality and human rights duties impact analysis for provider handbook on ambulance services.

In addition, contributions were received from a number of SpeakOut groups.

The information below provides a summary. You can read more detail and analysis of further qualitative feedback in the full report on our website.

Core services

Consultation question 1

We have identified the core services that we will check during our inspections of ambulance services. Do you agree that these are the right core services to look at?

Do you agree that, in general, core services should be weighted equally with the above exception?

What you said

Of the 33 responses we received, 30 agreed that these are the right services to look at.

Of the 32 responses we received, 24 agreed that core services should be weighted equally.

Our response

We acknowledge the complexities in an ambulance service and have worked closely with the sector to develop the set of core services that have been piloted within NHS ambulance trusts. We have evaluated our approach and the core services we inspected which has resulted in agreement that the following three core services will always be inspected for NHS ambulance trusts where they are being provided:

- Emergency operations centre
- Emergency and urgent care services
- Patient transport services.

We may also focus on additional areas where these represent a large proportion of a provider's activity or expenditure.

We agree to weight core services equally and in line with our commitment to promote equality. Everyone who receives care and treatment should expect to receive the same good quality care, irrespective of the type of service that they are using.

Key lines of enquiry

Consultation question

2. Do you feel confident that the key lines of enquiry and the list of prompts will help our inspectors judge how safe, effective, caring, responsive and well-led NHS and independent ambulance services are?

What you said

Of the 32 responses we received, 28 felt confident that the key lines of enquiry and the list of prompts will help inspectors judge how safe, effective, caring, responsive and well-led NHS and independent ambulance services are.

Our response

We agree that through our own evaluation work of both the pilot inspections of NHS ambulance trusts and inspections of other NHS trusts and independent services, key lines of enquiry and supporting lists of prompts provide a robust framework to focus an inspection, gather evidence, reach a judgement and report our findings.

To ensure consistency in our inspections and approach to regulation, we will use the key lines of enquiry and prompts that have been developed for the ambulance sector as the framework for inspections going forward for NHS ambulance trusts and in the development of our approach for independent ambulance services.

Ratings characteristics

Consultation question

3a. Do you agree that the characteristics of outstanding are what you would expect to see in an outstanding NHS and independent ambulance service?

3b. Do you agree that the characteristics of good are what you would expect to see in a good NHS and independent ambulance service?

3c. Do you agree that the characteristics of requires improvement are what you would expect to see in an NHS and independent ambulance service that requires improvement?

3d. Do you agree that the characteristics of inadequate are what you would expect to see in an NHS and independent ambulance service that was inadequate?

3e. Do you agree that rating all ambulances will achieve the purposes described in the Nuffield report?

What you said

- 28 respondents agreed that the characteristics of outstanding are what you would expect to see in an outstanding NHS and independent ambulance service. Four respondents did not agree.
- 29 agreed that the characteristics of good are what you would expect to see in a good NHS and independent ambulance service. Two respondents did not agree.
- 29 agreed that the characteristics of requires improvement are what you would expect to see in an NHS and independent ambulance service that requires improvement. Two respondents did not agree.
- 29 agreed that the characteristics of inadequate are what you would expect to see in an NHS and independent ambulance service that was inadequate. Two respondents did not agree.
- 23 respondents agreed that rating all ambulances would achieve the purposes described in the Nuffield report. Seven respondents did not agree.

Our response

We agree that these characteristics are sufficient to provide a robust framework, which, when applied using professional judgement, will guide our inspection teams when they award a rating. They will not be used as an exhaustive list and the inspection team will use their professional judgment, taking into account best practice and recognised guidelines. However, these will provide an effective framework to assist the inspection team to reach their judgements.

We agree to rate NHS ambulance trusts using the same rating principles applied to other NHS trusts from April 2015. However, we need to develop our approach to services we are not currently able to rate, which includes independent ambulance services, to decide which services it is appropriate to rate, and at what level.

What we are not able to change

The current legislation does not allow us to rate all registered services.

During the inspection

Consultation question

4. Do you think observing care, in or from, an ambulance is an appropriate way to gather evidence to inform the inspection?

What you said

Of the 32 responses we received, 29 thought that observing care, in or from, an ambulance is an appropriate way to gather evidence to inform the inspection.

Our response

We agree that it is important that we observe the provision of care to ensure we gather robust evidence to form judgements. We will observe care being provided to people by paramedics and emergency care assistants. This will involve emergency ambulance shift observations and the opportunity to speak to staff.

Consultation question

5. Do you think that 30 days is an appropriate period of time to complete an unannounced visit of an NHS ambulance service?

What you said

Of the 33 responses we received, 28 thought 30 days was an appropriate period of time to complete an unannounced visit of an NHS ambulance service.

Our response

We agree that following the announced visit the inspection team will normally carry out further inspection activities unannounced within a 10–15 day period. This is so our approach for NHS ambulance trusts is consistent with other NHS trusts as well as taking account of the burden on providers.

Rating and reporting

Consultation question

6. Do you agree that we should report on, and rate, core services at trust level?

What you said

Of the 28 responses we received, 27 agreed that CQC should report on, and rate, core services at trust level.

Our response

We agree that we will rate core services at NHS ambulance trust level. This is in line with our inspection methodology across other NHS trusts and will ensure consistency in our approach to reporting and rating.

When aggregating ratings, our inspection teams will follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their professional judgement. Our ratings must be proportionate to all of the available evidence and the specific facts and circumstances.

Consultation question

7. Due to the large geographical areas covered by NHS ambulance services, do you think we should rate core services at area level within an NHS ambulance service?

What you said

Of the 29 responses we received, 22 thought CQC should rate core services at area level within an NHS ambulance service.

Our response

We agree we will rate NHS ambulance trusts at core service level. We will also rate NHS ambulance trusts at location level rather than area level. This is to ensure our approach to reporting and rating NHS ambulance trusts is consistent with other NHS trusts as well as a trust's registration.

Consultation question

8. If we rated independent ambulance services, what would be useful – a rating at location level or at core service level?

What you said

Of the 27 responses we received, 14 thought it would be useful to rate independent ambulance services at a location level.

Our response

We will continue to develop our approach for those services we are currently unable to rate, which includes independent ambulance services. We will carry out pilot inspections of independent ambulance services and work with providers, stakeholders and the public during 2015 to decide which services it is appropriate to rate, and at what level.

What we are not able to change

The current legislation does not allow us to rate all registered services.

Consultation question

9. Do you think we should rate independent providers at corporate level?

What you said

Of the 26 responses we received, 18 thought that CQC should rate independent providers at corporate level.

Our response

We do not currently plan to rate at corporate level. However, we will be including the corporate level in our relationship management. We will periodically review our approach to corporate level assessment and provide updates to the sector if we consider changes to this approach are required.

Special measures

Consultation question

10. Do you think we should introduce special measures for independent ambulances?

What you said

Of the 29 responses we received, 24 respondents thought CQC should introduce special measures for independent ambulances.

Our response

We want to ensure that services found to be providing inadequate care do not continue to do so. Therefore we will introduce special measures with the purpose of:

- Providing a set of specific interventions within which we use our enforcement powers in response to inadequate care and work with, or direct providers to, other organisations in the system to ensure improvements are made.
- Providing a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action; for example, cancel their registration.

Primary care dental services

The total number of responses received was 350. These are broken down into six sections.

1. 107 responses to the 13 consultation questions were received:
 - 100 through the online webform
 - One through email
 - Six through written submissions.
2. We gathered views from 160 respondents at focus groups. We asked what questions inspectors should ask each dental practice around CQC's five keys areas (safe, effective, caring, responsive and well lead) when inspecting the services:
 - 16 of these responses were from young people aged 10-23
 - Four were from parents/family carers
 - Five were from support workers
 - The remaining responses were from the Public Online Community.
3. 112 respondents submitted responses to a discussion on Mumsnet.
4. Feedback was also obtained from an unknown quantity of respondents from specific population groups which experience problems across a range of care providers. From these groups, general issues about dental care were solicited.

These groups included:

- People who are HIV positive
 - People with learning disabilities
 - People from the travelling community
 - People who are homeless.
5. Three written submissions addressing general issues.
 6. Eleven written submissions addressing the consultation questions were received from stakeholders, which included:
 - A borough council
 - A consumer association
 - A large corporate dental service provider
 - Local dental committees

- National stakeholders
- Professional bodies.

Feedback was also obtained from 32 respondents through a series of SpeakOut groups:

- 10 people from Al Hayat Men's Group
- 8 people from People First Learning Difficulties
- 4 refugees and asylum seekers
- 6 people from Sifa Fireside
- 4 people from Derbyshire Gypsy and Traveller Group.

Encouraging improvement

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?

What you said

Of the 106 responses we received, 91 thought it would help providers to improve.

Our response

We are pleased there was support for our role in encouraging improvement. We recognise there are many organisations and approaches to encouraging improvement within the dental sector by setting clinical standards, providing guidance on best practice, and through monitoring of contracts and compliance with accreditation schemes.

Throughout the consultation many respondents made reference to checking individual dentists' clinical quality and patient outcomes; a role which used to be conducted by primary care trust specialist dental advisors. CQC's role is to monitor, inspect and regulate services, not individual clinicians. Clinicians are responsible for the quality of their outcomes but we will be asking providers about how they assure themselves about that quality.

Some of the responses in the consultation asked us to simplify our guidance. We hope that our new guidance for providers on how to meet the regulations of care will do this; the response to that consultation was very positive. In addition to that guidance and the primary care dental handbook, we will also be publishing a series of myth busters. These will help clear up some common myths related to how we regulate primary care dental services. This will also help ensure consistency in our inspection approach and in our judgements.

Consultation question

2. Do you think CQC should look for examples of good practice and include them in inspection reports?

What you said

Of the 103 responses we received, 86 thought CQC should look for examples of good practice and include them in inspection reports.

The top five themes for what to focus on were:

- Patients' experience – good outcomes, happy patients, clear treatment plans, adapting to patient needs.
- Where all essential requirements were exceeded.
- Consider using information from accreditation schemes such as those run by the British Dental Association and Denplan.
- Review against best practice improvements and good procedures.

The top five themes for how to share good practice were:

- Regular newsletters
- Well-presented website
- Publish reports/handbook of good practice
- Mentoring system/study groups/teamwork within dental community
- Email.

Our response

We are pleased there was support for the approach to look for examples of good practice. However, some of the responses and subsequent co-production events have identified confusion by what we mean. Some have confused good practice with clinical best practice. As a result, we have changed the terminology we will use and will refer to 'notable practice' instead of 'good practice'. By this we mean identifying what works well so that others can learn.

During our initial wave of inspection activity we have identified several areas of notable practice related to governance arrangements and how the practice is run. We will continue to work with our stakeholders to develop a clear view and common understanding of what constitutes notable practice and how we will share this to encourage improvement.

Ratings

Consultation question

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?

What you said

Of the 101 responses we received, 78 agreed with this approach. Two respondents, both professional bodies, neither agreed nor disagreed.

Our response

We agree with the majority of responses and will not rate primary care dental services in 2015/16.

Compared with other sectors we regulate, the primary care dental sector presents a lower risk to patients from poor safety and quality of care. We recognise that there would be significant and complex challenges to delivering ratings in this sector given that we will only be inspecting 10% of providers. Therefore we will not rate in our new approach, starting 1 April 2015, but reserve the option to do so in the future.

This will be clarified by the work of the Regulation of Dental Services Programme Board to develop proposals for what the future regulatory system should look like. The General Dental Council (GDC), NHS England, NHS Business Services Authority, Healthwatch England and CQC have agreed to work closer together as members of the Programme Board to review the approach to dental regulation and inspection across England, assess current arrangements and determine an effective model for regulation for the future.

Approach to Inspection

Consultation question

4. We have found that, compared to other sectors that we regulate, primary care 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 this approach?

What you said

Of the 101 responses we received, 76 respondents agreed with this approach. Three respondents neither agreed nor disagreed.

Our response

Several respondents wanted CQC to be more explicit about our risk criteria and stated that there should be a proportionate ratio of the different types of providers. Our scheduling is done on a regional basis and we have estimated the proportion of inspections which need to be completed, taking into account the different types of providers. Where possible, we will aim to ensure a proportionate sample from across all providers.

Some respondents wanted to know more about the data we would use to identify risk. During 2015 we will be developing our approach to intelligent monitoring within the primary care dental sector and we will work closely with stakeholders and providers. The work of the Regulation of Dental Services Programme Board will also be important to developing a common understanding of risk and how we can share information and data more effectively.

For our new approach we have identified a set of indicators which will help identify practices of greater risk to patient safety and the quality of care. These include:

- Providers who have been registered for more than 18 months and not had an inspection.
- Providers whom we have concerns about; such as, due to, whistleblowing, complaints or enforcement activity.
- Concerns shared by our partners such as the GDC and NHS England.

Consultation question

5. For the practices that we do not 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?
- Use the NHS Friends and Family Test (from 1 April 2015)
- Other (please specify)

What you said

Of the 101 responses we received:

- 67 suggested – request an annual self-declaration from providers that they meet the regulations.
- 15 suggested – make better use of information from our partners.
- Five suggested – use the NHS Friends and Family Test (from 1st April 2015).

There were 14 other responses.

Our response

We welcome these suggestions to how we can make intelligent use of data, evidence and information to monitor services while we develop our approach to intelligent monitoring within the primary care dental sector during 2015. We will continue to work with our stakeholders through our advisory group and consider specific suggestions, such as how to make best use of the NHS Friends and Family Test for NHS primary care dental providers.

More widely, we will explore how to make better use of information from our partners through the work of the Regulation of Dental Services Programme Board.

Consultation question

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?

What you said

Of the 99 responses we received, 86 agreed with this approach. Two neither agreed nor disagreed.

The top five themes of gathering pre-inspection information about services that do not have an NHS contract were:

1. From practices themselves/self-assessment
2. From patients – interviews/surveys/comments/complaints log
3. The same way as the NHS
4. Work with dental plan companies
5. Speak to the GDC/British Dental Association.

The majority of respondents agreed that CQC's approach would be effective.

Our response

We welcome these suggestions and will continue to develop our approach to pre inspection data requests (PIR). The information we are likely to ask providers to send will include:

- Quality monitoring information such as information about compliments and complaints.
- Information about employees.
- An up-to-date statement of purpose.
- Information about membership of any accreditation/good practice schemes.

Consultation question

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?

What you said

- 31 respondents said – in the weeks before the inspection
- 18 said – annually
- 49 said – annually, but with the opportunity for providers to update at any time.

Our response

We will be asking providers to send us information in the weeks prior to an inspection. We are mindful that we do not want to create additional burden on providers and we will work with our partner organisations, such as the NHS Business Services Authority, to identify what information could be shared as part of our approach to intelligent monitoring.

Consultation question

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?

What you said

52 respondents replied to this question and gave a wide range of suggestions. The most common were:

- Ask patients (15 respondents)
- Ask staff (six respondents)

Our response

During our wave inspections we asked providers to place our comments cards and comments box in the practice at least one week before we were due to inspect. This proved very popular and we received a large number of comments from patients. We will continue to use this approach and explore other approaches, along with talking to people who use services during our inspections.

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?

What you said

Of the 101 responses we received, 81 respondents agreed with this approach. Of the 20 who did not agree, the primary concern (nine respondents) was that dentists cannot be effectively inspected by someone without dental practice experience, and should preferably be another dentist.

Our response

Respondents raised questions about the knowledge of dental issues by inspectors and wanted to know more about the training they would receive.

We have developed a comprehensive training programme for our inspectors and specialist advisors involved in inspecting primary care dental services. Not only does it include training about the inspection methodology, it also includes training about some of the key areas of treatment and regulation within the dental sector.

We are also developing 'learning sets' where inspectors can continue to learn about the dental sector.

Inspectors who are new to inspecting primary care dental services will always be accompanied by a dental specialist advisor on inspection. On most occasions we anticipate a dental advisor to be present on an inspection.

Prompts and evidence

Consultation question

10. We have mapped the regulations to the five key questions that CQC asks of services.

Do you agree with our mapping?

What you said

Of the 99 responses we received, 89 agreed with the mapping.

Consultation question

11a. 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?

What you said

Of the 98 responses we received, 78 thought the questions would enable inspectors to judge whether or not a provider met regulations.

Our response

Following our consultation and further deliberation, we have revised the way in which we describe our approach to inspecting primary care dental services. In particular, we will now be using key lines of enquiry (KLOEs) rather than inspection prompts.

Consultation question

11b. Are the prompts relevant and do they ask the right questions?

What you said

Of the 48 responses we received, 29 said the prompts were relevant.

Consultation question

11c. Is there anything missing from the prompts?

What you said

Of the 35 responses we received, 18 answered no.

A further 17 left comments provided examples of how the prompts could be improved. Some comments said the prompts are too ambiguous, not specific enough to dentistry and to ensure that evidence is corroborated with observation and talking to patients. Some responses questioned the need for inspection prompts.

Our response

We welcome the comments received to make the inspection prompts and examples of evidence clearer and more meaningful for the primary care dental sector. To further align with CQC's inspection model we will refine the framework by changing the title of the prompts to KLOEs and to make clear that these map to the regulations. We will carry out an assessment of the quality of primary care dental services leading to a judgement about whether they provide people with care that is safe, effective, caring, responsive and well-led, based on whether the regulations are being met.

We have changed some of the wording to be more explicit about what we mean in the examples of evidence and, have included a specific reference to the inclusion of cost of treatment.

We will use KLOEs to ensure inspectors are consistent with the evidence they look for and to ensure consistency in judgement.

Consultation question

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?

What you said

Of the 99 responses we received, 81 felt confident that this would identify any areas of poor quality care.

Nine individual written submissions were received, which included:

- A borough council
- A clinical commissioning group

- A dental provider
- Local dental committees
- Professional bodies
- Stakeholders.

You can read the full text and analysis of these responses, and the above summaries, in the full report on our website.

Our response

The majority of respondents felt that the examples of evidence would enable a consistent approach to inspection and enable poor care to be identified.

We will continue to look at a range of evidence to judge whether a practice meets the regulations including the fundamental standards. This will include looking at aspects of the dental records such as treatment plans and medical questionnaires. We will talk to dentists and other members of the dental team and ask them specific questions about how they assess patients' need and involve people in treatment decisions, including the costs of treatment. We will also observe some of the process involved in maintaining equipment and cleanliness. We will ask providers to demonstrate to us how they ensure effective clinical standards are met.

During the testing of our new approach in December 2014 and January 2015, all inspection reports have gone through a quality review process. This has involved a panel of CQC staff including the heads of inspection for dentistry, policy staff, legal staff and a dental advisor. The purpose of the quality review panels is to ensure inspectors reach a consistent judgement about whether the practice meets the regulations. We are pleased that the quality of the reports has been very high and inspectors are reaching consistent judgements.

Our methodology includes a local quality review process and as of April 2015, we will review a sample of reports at a national level.

Independent acute healthcare sector

38 respondents replied to the eight consultation questions:

- 31 replied through the webform.
- 10 individual written submissions were received, including:
 - a borough council
 - a national regulator
 - national stakeholders
 - professional bodies
 - a trade association.

You can read the full text and analysis of these responses, and the above summaries, in the full report on our website.

During the consultation period, we have also been piloting our approach with independent acute hospital providers and gathering more information in relation to those services that we have referred to as single speciality and non-hospital acute services.

We understand both from the consultation responses and our own findings that some parts of the independent healthcare sector are more difficult to define than others. We will engage further with those providers referred to in the consultation documents as non-hospital acute providers and consult with the independent doctors during spring/summer. A separate consultation document is being developed for that sector.

Some of the feedback we received was relevant to one or more of the consultation questions. Where this was the case, we have responded to the feedback under the question it was directly relevant to.

The information below is a summary from the online webform feedback; you can read more detail and analysis of further qualitative feedback in the full report on our website.

Three groups of providers

Consultation question

1a. Do you agree that our approach to separating independent healthcare providers into three groups – as we describe in the handbook – is meaningful and appropriate?

What you said

Of the 33 responses we received, 27 agreed with this approach.

Consultation question

1b. If you are an independent healthcare provider, can you readily recognise which of the three groups you fit into?

What you said

The 20 responses received indicated a 50/50 divide in opinion. Full details on this can be found in the analysis report.

Our response

We agree with providers that we need to do more work to differentiate between the single speciality and non-hospital independent healthcare groups. Furthermore, we have agreed to hold back our testing of the non-hospital sector until we have a better definition of what services will be included in this group. We will engage further with these providers and consult with providers of independent doctor services, such as Specialists (consultants who are on the UK specialist register at the GMC) and who may work exclusively in the private sector or carry out some NHS work but are not exempt from registration, private GPs, private mobile call out doctors, travel vaccination clinics, slimming clinics). We will do this during the spring/summer.

What we are not able to change

Some responses related to 'fees' but as we have consulted separately on this subject we are unable to consider this as part of this consultation.

Consultation question

2a. Do you agree with the approach we are proposing for regulating independent acute hospitals?

What you said

Of the 31 responses we received, 29 agreed with our proposed approach for regulating independent acute hospitals.

Whilst the majority of respondents agreed with the approach, two comments related to the information request CQC makes as part of the pre inspection planning phase. General comments were also made about the size of inspection teams and the need to further develop our metrics. One respondent felt that we should take account of existing accreditation schemes.

Our response

We agree that further work needs to be undertaken in respect of pre inspection data requests (PIR). In response to feedback received during the testing phase of acute independent hospital inspections, we are reviewing the requirements to ask for financial information within the Provider Information Return (PIRs). We will be working with The Private Healthcare Information Network (PHIN) to develop metrics that can be accessed through the central collection of data. We will look to develop metrics for independent healthcare providers that could potentially be used for intelligent monitoring purposes. We will be looking at all available data sources to help support inspection of independent single specialties.

We agree that our inspectors need the skills and knowledge to understand the differences between the Independent healthcare and NHS acute sectors. We will review our inspector training to ensure that our workforce has the appropriate skills and knowledge to undertake Independent healthcare acute hospital inspections. For single speciality hospitals, we have already developed and delivered a training programme for one of the single speciality services ahead of the pilot inspection. We will evaluate this training and consider how this model can be adapted for the wider range of independent healthcare inspections. We have also reviewed our specialist advisor team skills and experience and are steadily building on this expertise to develop our inspection team capability in line with our inspection priorities.

We will undertake further work to determine how established and recognised accreditation schemes can support our intelligence led view of services.

Approach to inspection

Consultation question

3. Do you agree with the approach we are proposing for regulating single speciality services?

What you said

Of the 28 responses we received, 25 agreed with our proposed approach for regulating single speciality services and supported the plan of grouping some single speciality inspections within a set timeframe.

Respondents identified the need to plan inspections with other inspection bodies, such as Clinical Pathology Accreditation, and avoid duplication. The need to test methodology prior to roll out, particularly in relation to diverse single speciality providers such as diagnostics, was identified.

Our response

We will continue as planned, to test our approach for single speciality providers over the next six months. Where possible we will group single specialities together. However, this may be dependent on the number of registered locations in each single speciality group.

Work is currently underway to determine how we can work with recognised accreditation bodies to support both our intelligence led approach to inspection and to reduce the burden on providers. We will continue to develop our work in this regard.

Over recent months we have continued to review the groups we defined in the consultation document as single speciality. Following this review and the consultation feedback we have decided that hair transplantation services will now move to the non-hospital independent healthcare group.

Consultation question

4. Do you agree with the approach we are proposing for regulating non-hospital acute services?

What you said

Of the 29 responses we received, 26 agreed with our proposal for regulating non-hospital acute services.

Although the majority of respondents agreed with our approach, comments to earlier questions raised the concern that the definition of 'non-hospital acute group' was unclear. The importance of engaging with patients and the public was also highlighted in the feedback as important.

Our response

We accept that further work is needed to define this group and our approach. As explained earlier, we will engage further with the non-hospital independent healthcare group of providers and consult with the independent doctors sector during spring/summer. A separate consultation document is being developed for that sector.

The inspection handbook and framework outlines our commitment to using experts by experience as part of our inspection teams. This will continue and we will review and improve on our approach to engagement with patients and the public for all sectors to improve our understanding of the patient experience.

Consultation question

4a. Do you agree that we should continue to engage with non-hospital acute providers before deciding on ratings?

What you said

Of the 29 responses we received, 27 said we should continue to engage with non-hospital acute providers on ratings.

Our response

Through our pilot work we are testing ratings for independent acute hospitals and applying shadow ratings to those locations inspected between January 2015 and 31 March 2015. We will evaluate our findings and adjust our approach should we need to. We plan to develop and test our approach to rating single speciality services between July and September 2015. We will continue to develop our approach to those services that we are currently unable to rate.

What we are not able to change

The current legislation does not allow us to rate all registered services.

Consultation question

5. Do you feel confident that the changes we propose to the acute provider handbook will help our inspectors to assure the public on how safe, effective, caring, responsive and well-led independent acute hospital and single specialty providers are?

What you said

Of the 26 responses we received, 21 agreed that the changes proposed will help inspectors to assure the public on how safe, effective, caring, responsive and well-led independent acute hospital and single speciality providers are.

Some respondents were unable to answer this question as they were unclear which group they fit in to. There was overwhelming support for ongoing engagement with providers to support development of our methods.

Our response

Our characteristics of ratings outline the evidence needed to support our ratings. We will continue to use this as our reference point. The first ratings for the acute independent sector will be issued from April 2015. These will be available on our website.

CQC will continue to develop its understanding of the sectors, their diversity and how they align with CQC directorates and undertake co-production and engagement with both the public and providers.

Consultation question

6. Do you have any suggestions for how we could develop our approach to special measures in the independent acute sector? [open ended question]

Respondents were cautiously supportive of special measures but consistently commented that special measures needed to be identified as a lever for improvement.

Respondents questioned how we would balance the different market and competitive contexts when comparing special measures in the NHS to the independent sector.

Consultation question

7. Do you have any suggestions for how we should or should not develop our approach to corporate provider assessment in the independent acute sector?

What you said

15 respondents felt that we should take account of the corporate level function.

Our response

While we have no current plans to rate providers at the corporate level, we will review our approach to provider relationship management and strengthen these arrangements where we can.

We will periodically review our approach to corporate level assessment and provide updates to the sector if we consider changes to this approach are required.

Appendix: Organisations that submitted responses

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| <p>Health and social care providers and bodies</p> | <p>North Devon Orthodontic Centre Ltd Park Clinic</p> |
| <p>Ambulance service providers Bristol Ambulance EMS East Midlands Ambulance Service NHS Trust East of England Ambulance Service NHS Trust North West Ambulance Service NHS Trust NSL Limited South Central Ambulance Service NHS Foundation Trust South East Coast Ambulance Service NHS Trust West Midlands Ambulance Service NHS Foundation Trust St John Ambulance</p> | <p>Pasadena Dental Practice Ltd Primecare Oral Health Queens Park Dental Team Ltd Queensway Dental Clinic R M Allen Dental Practice Romsey Dental Care Ltd S.G Wade Dental Practice SM Dental Care Ltd Sweet Smiles Dental Practice University of Portsmouth Dental Academy Victoria Dental Practice Wallington Dental Surgery Yarde House Dental Practice</p> |
| <p>Dental Practices Albany Dental Practice Battersea Orthodontics Limited Bhandal Dental Practices Birchfields Family Dental Care BUPA UK Colne View Dental Surgery Coombe Dental Care Ltd Corner House Dental Practice Dawn Brooks Dental Practice Dental Care Direct Eden Villas Dental Practice Integrated Dental Holdings Ltd Lighthouse Dental Practice Lyndhurst Dental Practice Moreton Road Dental Practice</p> | <p>Healthcare Providers Bespoke Healthcare Limited British Pregnancy Advisory Service British Red Cross Coventry and Warwickshire NHS Partnership Trust HCA International Hi MoM - 3D Ultrasound Scan Facility Pure Sports Medicine Ramsay Health Care UK Sheffield Orthopaedics Limited Sprire Healthcare plc The Dove Clinic The Medical Practice 48 Wimpole Street LLP The Well - One Clinic</p> |

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|---|--|
| <p>Trade associations Independent Healthcare Advisory Service</p> <p>Local authorities/Commissioners Blackpool Clinical Commissioning Group Hartlepool Borough Council NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group NHS England Wessex, Dental Commissioning Team Yorkshire and Humber Commissioning Support Unit</p> <p>Other groups British Standards Institution Compassion in Dying Healthwatch Cambridgeshire Healthwatch Leeds Healthwatch Norfolk Leicestershire Police National Ambulance Commissioners Network National Ambulance Diversity Forum Patients' Forum for the London Ambulance Service PHE West and East Midlands Dental Private Healthcare Information Network Public Health Network Which?</p> | <p>Charitable and voluntary organisations Care Sandwell</p> <p>Professional representatives/bodies British Dental Association British Medical Association Consultant Eye Surgeons Partnership Cornwall and Isles of Scilly Local Dental Committee Denplan Ltd Faculty of Dental Surgery Faculty of General Dental Practice (UK) General Medical Council Lincolnshire Local Dental Committee Monitor NHS England NHS Providers NHS Partners Network Royal College of Nursing Royal College of Physicians of Edinburgh The Royal College of Surgeons Wirral Local Dental Committee</p> |
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