



Report Detailing the responses to the CQC Consultation on How to Regulate Primary Dental Care Services

March 2015



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1. Introduction

About the consultation

CQC ran a consultation between 28 November 2014 to 23 January 2015, where they asked members of the public, stakeholders and providers, about their plans to change the way we regulate the following services:

- Ambulance services
- Primary care dental services
- Independent acute healthcare services.

About Quality Health

Quality Health is an independent healthcare consultancy, commissioned by the Care Quality Commission to support this consultation process. The consultation documents and the various processes for collecting feedback were designed and organised by the Care Quality Commission.

Quality Health has collected all the response data from all aspects of the process and captured it in this document.

Any conclusions reached in this report are therefore the conclusions of Quality Health based solely on the responses provided to the consultation; they do not necessarily represent our own views or the views of the Care Quality Commission.

You can read the full consultation response on the CQC's website here –

www.cqc.org.uk.



2. Key numbers

The total number of (known) responses received was 414. These are broken down into 6 sections.

1. **107 responses** to the 13 consultation questions were received, 100 via the online webform, 1 via email and 6 via written submissions

58 of these responses were from Healthcare Professionals, 31 were from Providers of Services, 9 were from Members of the Public, 2 were from Stakeholder, 1 was from a Voluntary and Community Sector Representative 1 was from a Commissioner of Services and 5 were from Professional Bodies.

2. **160 respondents' views** were solicited via focus groups and these were asked what questions inspectors should ask each dental practice around CQC's 5 keys areas (safe, effective, caring, responsive and well lead) when inspecting the services.

16 of these responses were from young people aged 10 – 23, 4 were from parents/family carers and 5 were from support workers while the remaining 135 were from the Public Online Community.

3. **112 respondents** submitted responses to a “sponsored 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 include people who are HIV +, people with learning difficulties, travellers and homeless people

5. **3 written submissions** addressing general issues

6. Feedback was also obtained from **32 respondents** via a series of speakout groups

This report is accordingly broken down into 6 sections.



3. Responses to 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?

Of the 106 respondents who answered this question, 91 respondents thought it would help providers to improve, some adding further comments as follows:

Healthcare Professionals

- In addition to themed inspections focused on improvements in care and services provided it may be advantageous to include IC / decontamination as a themed inspection as this has been an area in primary dental care where compliance has been poor.
- However, I feel that the CQC can be quite harsh and unhelpful and when Dentists are trying their best to provide an excellent service for patients, trying to deal with complicated requirements could possibly have the implication of taking the focus away from the treatment of the patients to ensure these requirements are met. Maybe it could be made less complicated?
- A qualified "yes". The measurement of "improvement" without clear metrics is problematic and potentially inequitable. The absence of ratings in the dental sector, and clear guidance on what would constitute "outstanding" practice, together with the prospect (for some time), of the majority of practices not being inspected, causes issues. It could be said that by the very nature of its activities, CQC "improves quality" by assuring that standards are achieved, maintained and, over time, updated in line with legislation and regulation



Providers of Services

- We have answered yes here but would like to add comments: We believe that clear expectations are essential. Sharing information can only be helpful. However, we believe that one needs to be mindful regarding using evidence as what constitutes good care to set expectations. Dental practices differ enormously and what works for one practice may be impossible to achieve. For example, a welcoming, bright and airy reception room may be deemed as contributing towards good patient care however, some practices may not have the physical space to be able to achieve this.
- But only if applied as above and ensuring approach is consistent, in particular regards the enforcement action taken, we see too often that the approach by inspectors varies drastically from region to region,
- Yes it should but may be limited by only inspecting 10% of practises- there is a risk of not capturing those that need the most improvement

Professional Bodies

- We agree that this approach should help providers improve, but the information on the CQC's expectations and explanations of where practices are not complying needs to be clear and unambiguous. Many dentists complain that the guidance given – and the comments in the associated reports – do not give a busy practitioner enough pointers as to how they might comply with the Regulations. Providers must have easy access to examples of good and poor practice and examples must be relevant to general dental practice and realistic. How does CQC intend to make this information ready available to all dental providers?
- We believe that this combination will help to drive improvements in service quality across primary care dental services. We believe it is important to share information with other bodies, in order to build a clear picture on the levels of risk, and where there may be particular areas of concern. This is particularly important for providers of private services who do not hold an NHS contract, and for whom there could be less information available.
- We support the measures suggested by the CQC to encourage services to improve. In particular, we agree that carrying out appropriate themed inspections will help to raise issues at a national level and gather evidence of what good care looks like. For example, the CQC could examine whether practices have the necessary facilities to provide the appropriate range of care within the primary care setting.
- We would, however, highlight the need to ensure that all of the practices inspected (either through random or targeted selection) are subject to equitable assessment parameters to allow both patients and the profession to



extrapolate meaningful and comparable information. Furthermore, we cannot emphasise more greatly the necessity for an experienced dental professional to be present at each inspection; not only will this be essential to achieve confidence in the process from the profession, but will provide the means to verify information and assess practice based on first-hand knowledge and skills.

14 respondents (8 Healthcare Professionals, 4 Providers of Services and 2 Members of the Public) didn't think it would help providers to improve and gave the following reasons:

Healthcare Professionals

- What are the qualifications of the experts? Without experience of general dental practice their opinions are worthless
- I have never read so much rubbish in my life. So much on politically correct rubbish and minimal content on treatment quality
- All checks to ensure systems are in place are required but what you need to do is introduce a dental examination of 10 consecutive patients who have received a course of treatment and also talk to them about the service they received from the practice.
- Definition of good practice is very "woolly" - doing more than the regulations require and unclear what sort of answers you would expect. Surely the regulations should be structured initially to ensure good practice at a realistic and appropriate level and practices measured against this.(NOTE needed to answer no in order to be able to put in this comment as boxes in question 2 do not ask for general comments)
- Too much regulation too little education
- Dentistry is far more complex and very difficult for CQC to estimate a provider's performance and the quality of care provided by the means of having policies and inspections in place.
- Paperwork easy to fill in - you need to look at PROPER CLINICAL QUALITY bring back dental reference officers and spot inspections on patients.
- What is different to now? Personal experience has been that inspections tend to lack clarity and are too generic but when this has been raised by anyone we are told that it is all laid down in your documents so does this mean that you are admitting it is presently unclear?

Providers of Services

- Because you "get in the way". We do not need your pettiness in dentistry as we, as professionals, are the ones who know best and your organization and



inspectors haven't a clue. You have lost the plot and it was pathetic dealing with your inspector.

- Dentists are morally, financially and ethically obliged to provide the best care they can. CQC threats will not change the habits of the bad eggs they will do a "top show" improvement but carry on regardless.
- Sharing information on only good practices would help other much more efficient

Members of the Public

- I have struggled to find an NHS Dentist in my area. Now I have found the one dentist in my area, they seem keener to sell me private treatment, than provide good quality dental care; each appointment feels like a sales pitch rather than a dental care service. I don't believe the bullet points above would resolve this issue.
- This is one of those "have you stopped beating your wife" questions. In theory, the answer should be "yes", and would be if the CQC went about their business in a more provider-friendly way. But deluging practices with bureaucratic output, much of which has to be searched for on poorly-compiled websites (often, material that is not relevant to the individual addressee) poses a serious risk of hampering the genuine clinical work that is to be done. It cannot be argued that regulation per se is a bad thing, but the mission-creep that surrounds the CQC's way of business, and the organisation's constant attitude that clinicians have nothing better to do than spend hours each month in wading through CQC output, poses a real hazard to the provision of maximal dental care. Interestingly, this questionnaire does not even provide the ability for me to answer in my real capacity. I am not a provider or a healthcare professional, so I must answer as a member of the public, when I am, in fact, a consultant who provides CQC compliance advice to the dental sector.



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

Of the 103 respondents who answered this question, 86 thought CQC should look for examples of good practice and include them in inspection reports and 16 respondents (9 Healthcare Professionals, 5 Providers of Services, 2 Members of the Public and 1 Professional Body) didn't think CQC should look for examples of good practice and include them in inspection reports.

Respondents gave the following examples of what best practice would look like:

The top five themes are shown in the table below followed by example quotes

What would best practice look like? Main themes	Healthcare Professionals	Providers of Services	Other	Total
Patients' experience. Good outcomes of patient care/ happy patients/ clear treatment plans/ adapt to patient needs	11	4	3	18
If all essential (including clinical) requirements and standards are consistently met exceeded/ compliance with all regulations.	11	3		14
BDA, Indemnity society, Denplan etc., accreditation / standards	3	1		4
Constant review against best practice and improvements. Good procedures for review and training/regular team meetings	2	2		4
Best practice very different for different practices	3		1	4



Healthcare Professionals

- It is multifactorial. Your inspection criteria probably preclude an accurate assessment. Actually listen and take advice from experienced GDPs
- Good outcomes of patient care
- If you have to ask, you should be disqualified from checking it.
- Have a clear idea of what clinical components are required to ensure a practice is run well. Whilst the emphasis has been placed wholly on items present e.g. logs and number of hand-pieces etc., in the past the current practice of 'outcome based' over emphasizes the results through assessment of paperwork. This has gone too far the other way. There needs to be a balance of real inspection and paper based inspection.
- Happy, satisfied patients who have attended for a long time because they appreciate the efforts made by the whole practice to make them welcome and ensure that they are well cared for across the board.
- If all essential requirements are met.
- I believe the outlines set out below are excellent indicators of best practice. .Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led? Keep the underlying regulations simple and to the point, try not to create something which is far too complicated and can easily be miss-interpreted. SIMPLE and PATIENT FOCUSED regulations. When running a service principles/managers need easy to translate universal advice on how to improve their particular clinic.
- Written treatment plan, clear explanation which is private and which is NHS within a treatment plan. Infection control, customer service, prevention, etc.
- I am not sure that good practice needs to be included in inspection reports for now. My view is that the public expects CQC to be focused on patient safety (in all its aspects). The BDA has a 'Good Practice Scheme' that practices can apply for.
- Need to decide on definition of good practice as starting point if you are going to look for examples of it. Surely complying with the regulations is good practice!
- From an infection control perspective practices should be encouraged to meet the Best practice standards described in HTM01-05 and it should be used as a marker for good practice- in summary a separate dedicated decontamination room provided (that meets the standards, storage of instruments out of the clinical area and use of a validated washer disinfecter for the cleaning of all dental instruments prior to sterilisation.



- Audits completed to adapt the service to patients' needs, clear and structured template for the overall monitoring of the service.
- Good practice will vary depending on the circumstances of individual practices. One model will not fit all.
- Good practice is that in which a well-managed team works effectively and productively to deliver care that is consistently of a high standard and which continuously reviews its processes and outcomes, skills and knowledge, with a view to improve them for the benefit of patients and itself.
- There are a wealth of examples available from the BDA, Indemnity societies and Denplan etc. What is clear is that adopting gold standard expectations (such as those from FGDP(UK) as a baseline and then being surprised when many practices do not meet these aspirational expectations is not the right approach. The above organisations show many examples of progressive and structured approaches to achieving better and best practice and should be used as the starting point to raise standards to the required level.

Providers of Services

- This is political clap trap jargon and gets in my way of continuing to provide excellent dental services. I cannot be doing with this government "speak".
- CQC should look at whether a practice reaches a specific level of standard. CQC should NOT be the body that determines the standard!

Members of the Public

- Good practice would be interactions with staff and patients, from Receptionist to Dentist, are patients put at ease before any procedure? Are health checks done before any procedure ie patients medication, can patient sit/lie comfortably in the chair. Assessing the answers given by staff on their practice and response from patients using the service
- Good practice must be patient focused, to deliver the best care outcome for each individual patient.

Professional bodies

- It can be difficult to identify objectively what constitutes good practice; it is not always evidence-based and what is regarded as good practice for one provider may not be appropriate for or enhance the service provided by another. Providers can be creative in the ways that they operate their services but 'good practice' will vary. We would, of course, be willing to contribute to discussions on what good practice looks like, but CQC should recognise that it may be difficult to gain a consensus in some areas. Our advice provides an opportunity for highlighting and promoting recognised good practice. The



question suggests that CQC inspectors might identify examples of good practice and include them in inspection reports. This poses the challenge of consistency to ensure that what is recognised as good practice applies across the whole sector.

- Good practice should be based upon existing evidence based guidelines and principles of good patient care (including guidance already published such as PHE Delivering Better Oral Health). Good practice will also include monitoring of processes and outcomes.

Respondents suggested the following ways of sharing good practice to promote learning between providers:

The top five themes are shown in the table below, followed by example quotes.

Ways of Sharing Best Practice. Main Themes	Healthcare Professionals	Providers of Services	Other	Total
Regular/ monthly newsletters/bulletins	6	6	1	13
Well-presented website with best practice guidelines/ forum for ideas/ examples of best practice	56	1	4	11
Publish reports/ handbook of good practice guidelines/ guidance/ examples	5	1	1	7
Mentoring system/ study groups/ teamwork within dental community	2	3	1	6
Email	2	2		4

Healthcare Professionals

- By putting it in monthly news letter
- We all know how to provide quality work.
- Through guidance newsletters.
- Patients could complete a short questionnaire regarding defined good aspects and rate the practice themselves. This data could then be accessed



anonymously as examples of how other practices could help improve their services

- Publishing Good practice guidelines
- Consider providing time limited awards to good practices.
- When running a service principles/managers need easy to translate universal advice on how to improve their particular clinic. A well-presented website with easily accessible info/ advice is how I believe good practice should be shared.
- Put it on a website
- Email
- Webinars are excellent and accessible to all. If free and provide verifiable CPD this would be your best chance of promoting.
- Publication in reports or standard publications include examples in guidance / handbooks
- Inclusion into the final report would not only allow other providers to see examples of how areas of good practice have been achieved within the inspected service but would also promote the inspected practice to continuously strive to improve on the service they deliver.
- Examples of good practice could be given and recommendations for services or products used could be given.
- Mentoring system for those practices who need to improve areas to reach satisfactory. Do not believe that healthcare providers do not continually strive to improve but some may need help to reach satisfactory levels for any number of reasons.
- Report on examples of good practice within the narrative of our inspection reports

Providers of Services

- Butt out of our lives and let us and our own organizations deal with this.
- Monthly update of 'good practice' standards - BUT this idea of good practice needs to be scientifically verified with robust clinical evidence. It should NOT simply be based on CQC inspectors' idea of what looks like good practice!
- Regular e-mail updates sharing good ideas from other practices and any regulatory changes that you wish us to adapt to.
- Though seminars, bulletins and provide reports to all providers on what good practice entails. Possibly practical demonstrations could be useful.
- Perhaps a development programme with the practice with the right standards to help other practices who are struggling. thus promoting team work within our community.



- Highlight ways in which different types of dental service providers meet each different fundamental standard. Show us how a one man practice does it, a multi-disciplinary practice does it and dental services in the hospital setting do it

Members of the Public

- Promote providers that are showing good practice, encourage other providers to look at what they are doing differently. Encourage patients to give feedback and learn from what is said in those comments. Ask providers what they look for in the practices where they themselves receive treatment.
- Forums, newsletters.

Commissioner of Services

- Validated good practice reports should be shared separately on the CQC website.

Stakeholder

- When shared help others learn, possibly promote some competition

Professional Bodies

- In addition, any good practice identified - while being mentioned in the individual report – should also be replicated in a more central area, due to the limited audience of those individual reports.
- It is essential that clear information pathways are developed to disseminate information to the profession and other stakeholders. Relevant information will need to be easily accessible and well promoted to dental professionals and other stakeholders.

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?

Of the 101 respondents who answered this question, 78 agreed with this approach, with 7 respondents adding the following comments:



Healthcare Professionals

- Dentistry is highly individual and subjective; the old adage 'you are only as good as your last filling' is very relevant because your last filling may be your best ever or your worst, depending on a variety of factors, a lot of which are out of the dentist's control. A star rating will lead patients to believe that their dentist might not be good enough and this is highly dangerous.
- But you cannot rate dental services as they are very diverse
- Rating should be based on clinical examination of patients and talking to patients from the practice
- I believe a rating system is a good way for patients to make informed choice for where they can access good treatment.
- Even though I said yes to this I would like to comment. The problem with only rating a few (based on the 10% inspection model) is that the majority would not be rated. The public do look at this type of data for many other services and where this might be adverse it could affect judgement. If another equally failing practice has not been inspected and hence rated a potentially vital piece of information is missing. It may be better to consider a practice 'rating' based on all of the other information currently available and suggested for the future (such as FFT).

Provider of Services

- ...but please don't keep moving the goalposts - give us a standard to work to and stick to it unless good evidence says it needs changing
- Each dental care provider is different and I believe should not be rated

22 respondents (15 Healthcare Professionals, 2 Members of the Public, 1 Provider of Services, 1 Voluntary and Community Sector Representative, 1 Commissioner of Services, 1 Stakeholder and 1 Professional Body) did not agree with this approach and gave the following reasons:

Healthcare Professionals

- The services need to be rated, otherwise there is no comparison.
- Until the CQC has the respect of the profession its ratings are worthless .
- I do not believe you are fit for purpose. I have been present on previous CQC inspections too.
- It will make providers slip in their standards if they know they are not rated
- Again need to answer NO in order to provide a comment! You should be aiming to provide a benchmark below which no practice should be allowed to



function. Rating of practices is always going to be subjective as no 2 practices are the same. Equally patients' experiences and perceptions of the same practice can vary hugely. If we are responding to patients as individuals and providing for their needs on that day at that time with that problem how can practices, which are all individuals be grouped into 4 categories. The ethos of the individual should work both ways.

- Dental services should be rated in line with all other services, I feel there needs to be a consistent approach for all and not sure why dental services would be excluded from rating. In my experience where rating systems are used practices make extra effort to achieve a high rating particularly when the information is shared with the public. Further to my comments above on what good practice would look like dental services wouldn't be given the highest rating for safety if they were not meeting the Best practice standards
- Inspections should be regular and thorough. By skipping a year means that practices can slip in standards by feeling they have a year off
- Needs to be sooner, there is plenty of bad practice that happens and also very good practice that needs rewarding
- The imposition of ratings should be postponed until all practices have received an inspection under the new (2015) Regulations and approach.

Provider of Services

- Even then, we don't want you getting in our way with your stupid things that you do.

Voluntary and community sector representative

- Why are you not able to rate primary care dental services in 2015/16, I can see no explanation in the handbook

Members of the Public

- Many practices operate through a referral system and such a rating could destroy a business and a clinical reputation which may have taken years to build up. These is not like restaurant business but are providers of complex clinical treatment which is not simply assessed through a "star" award
- There aren't enough high quality primary care dentists.

Stakeholder

- Why are other services rated but not dentistry it should be all inspected and regulated



Professional Body

- We do not support ratings in dental practice. The CQC must be clear about why it would rate dental providers. The limited research that is available has shown that patients pay little regard to health care ratings other than for care homes, so using ratings for dentists will be of little use to the public.

Commissioner of Services

- Unsure of the reason behind such a decision. How would the outcome of CQC assessments support patients in exercising informed choice without an easy to use system? Ratings would prove useful.

2 respondents, a both Professional Bodies, neither agreed nor disagreed but commented:

- The group felt it was important that the new inspection process needs to be established and working well before any further changes are considered.
- A system to grade compliance could be considered in the future, however it is important to understand the many factors that may influence individual practice conditions and service delivery, including the differing funding systems referred to above. We would question how a rating of outstanding/excellent could be defined across the five key domains, particularly since the only area where this is defined at present is in infection control (within HTM01-05), and it remains difficult to envisage any rating system other than good/requiring improvement/inadequate.

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 this approach?

Of the 101 respondents who answered this question, 76 respondents agree with this approach with 3 (both Professional Bodies) adding additional comments:

- We do on the understanding that it is to be 5% risk-based and 5% random. However, recent revelations by the CQC have shown that more than 5% of practices show up as being "at risk" ones (although early figures indicate that only 75% of these are validated). With the increase in the number "at risk" and a 5% random element, we are concerned that the CQC's 10% target will be exceeded.



- We agree with this proposed approach. However, we feel that it is important to be able to monitor all providers (beyond the 10% that are inspected) to ensure that they are meeting regulations. Whilst there will be some information available through partners such as Healthwatch England and NHS Area Teams, there are a proportion of services that do not currently have an NHS contract. Consideration should be given to how these practices can be monitored by other bodies, and whether new information services will need to be developed to support such monitoring
- It will be important to ensure that the 10% of practices being inspected covers a proportionate ratio of those providing NHS, private, specialist and community dental services treatment in primary care settings. However, it is difficult for the FDS to comment on whether the CQC should take a 'risk-based' approach to inspection without understanding the data and methodology that will inform this. It is extremely important that any risk analysis uses data that is up-to-date and supported by the dental profession to provide confidence in the inspection methodology. This is particularly the case given that the CQC's signposting document makes clear there is 'limited evidence about patient safety in primary dental care'. We urge the CQC to detail how they will identify 'at risk' providers as soon as possible. We would be pleased to continue to work with the regulator to support this work.

23 respondents (15 Healthcare Professionals, 1 Provider of Services and 5 Members of the Public, 1 Stakeholder and 1 Commissioner of Services) don't agree with this approach, giving the following reasons:

Healthcare Professionals

- Because some practices are better at reports than care.
- How can you establish the spectrum of standards without purely randomised inspections?
- You will visit enough practices to justify your existence.
- If you are only going to inspect 10% of practices, you might as well leave it to 'market' to get the quality right in dental practices. You need to inspect all practices in a 3 yearly rolling programme and examine patients from random 10% of the practices.
- I think you should keep up the pressure of an inspection on the providers at all times to ensure quality checks are maintained.
- Priority should always be given to practices causing concerns, and how do you know that your intelligence won't take up the full 10%. Also the random element of the other inspections needs to be controlled as someone could be



randomly selected every year and another practice never if it is a truly random selection.

- From an infection control perspective the degree of risk in primary dental care services is higher than other services - in brief; dental services are undertaking local decontamination (on site reprocessing of dental instruments) with inconsistency of standards dependent upon what level of standards are met, knowledge and experience of staff and lack of monitoring of decontamination procedures in use. Increased exposure to blood / blood stained bodily fluids (higher when oral surgery / implants undertaken) increased handling of sharps instruments and needles, increase risk to staff as well as patients. Aerosol generating procedures routinely undertaken.
- This would possibly mean dental sites only get inspected once every ten years. A lot could go wrong in that time.
- All providers should be inspected. Self-regulation should not really be used as it is not the best form of regulation to keep patients safe.

Members of the Public

- My family has visited Dentists who undertake NHS work. In most cases patients are not seen by qualified dentists but by Assistants. Which is unsatisfactory. At least the first consultation must be with a qualified dentist.
- To say that dental practices are lower risk seems strange to me, body fluids are more prevalent in dental practices than many care providers, i.e. blood and saliva. If you imagine someone has had an extraction and then leaves the building touching surfaces and the next patient calls in for a check-up and touches the same surfaces which may not have been cleaned sufficiently and then has a sandwich for lunch? There is a great deal of concern at the moment with cross contamination with the outbreak of Ebola. Of course at the moment we have no such outbreak here but blood Borne disease should not be over looked.

Providers of Services

- Even 10% don't want you around. Leave the dentists alone.
- How far will a patients treatment be looked into? For example; I had several teeth removed at my local hospital where I was referred by my dentist. Following that operation I now have further health issues. Therefore, would you be looking at referrals from Dentist and where a patient received their treatment, and if they were not satisfied, have they complained, have they been listened to, did they return to the same dentist?

Commissioner of Services



- Historically the NHS assessed 33% of contracts each year, as requirements change frequently and so it was key to ensure each contract remained up to date. 10% is considered too low.

Stakeholder

- There may be under-reporting on care that is not safe in areas where demand for dentists is high patient reporting of concerns is likely to be low. Acceptable access for whole populations should be part of the inspection. Consider recent WHICH work and West Yorkshire joint work on access led by Healthwatch Kirklees

3 respondents neither agreed nor disagreed but commented.

Professional Body

- The group was uncertain how the model of risk would be constructed and queried if the model will include information obtained from outside the CQC? Information from other sources (such as NHS England) may help to create a more meaningful risk assessment. The group also thought that the frequency of reviewing the model would need to be considered carefully.
- The group was also unsure how frequently practices will be inspected- does it mean that a 'low risk' practice would have a frequency of inspection of less than once every 10 years? Or did it mean that a low risk practice could be inspected *at a minimum* at least once every 10 years (10%)?
- Ideally, all providers would be inspected on a regular basis, particularly since the practice environment can quickly alter with change of ownership. However, we would agree that a model of risk-based and random selection should ensure that practices comply with the Health and Social Care Act and regulations, while a 10% inspection rate would seem reasonable given the relatively low risk to patient safety. It will be important to ensure that, of the randomly selected practices of the 10% being inspected, there is a proportionate ratio providing NHS, private, specialist and community dental services treatment in primary care settings. It may be helpful to consider the development of a low cost, scalable, online mechanism in the future to check essential compliance on an annual basis. For instance, all dental practices could upload a sample of policies, audits, patient feedback, x-ray maintenance, and fire/safety assessments, and practices which don't comply can be highlighted for inspection. Such a system would help to avoid poor practice slipping through the net. However, it is essential that there is cross reference with all other inspection bodies (eg, the GDC) so as to avoid duplication and over-inspection of practices; the development of any future



system of continuing assurance (formerly revalidation) by the GDC, may serve a similar purpose in some aspects of practice.

Provider of Services

- Does this mean that higher levels of 'focused' inspections will lead to fewer 'comprehensive' inspections if the proposed 10% includes both risk and random.

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

Of the 101 respondents who answered this question:

- 67 replied "Request an annual self-declaration from providers that they meet the regulations"
- 15 replied "Make better use of information from our partners"
- 5 replied "Use the NHS Friends and Family Test (from 1st April 2015)"

"Other" responses included the following:

- 4 respondents replied "don't inspect"
- 1 respondent replied "It's impossible to do and you should realise that",
- 1 respondent replied "Have a rolling programme of routine inspections over a longer period of time"
- 1 respondent replied "You've found the majority of practices care for their patients well so trust us"
- 1 respondent replied "Encouragement and trust to continue good habits would go a long way for the good guys"
- 1 respondent replied "Independent cleaning audits with written reports should be done and these reports could be submitted"
- 1 respondent replied "Online booklet"
- 1 respondent replied "Patient checks"
- 1 respondent replied "Of the ones suggested, an annual legally-binding statement could be produced stating that, to the best of the dentist's



knowledge, they are meeting the requirements on the day that the statement was made”.

- 1 respondent replied “A combination of self-declaration, partner information and the NHS Friends and Family Test could assist CQC with on-going monitoring of all providers. In addition, we consider there could be an opportunity for externally-run, accredited service schemes to support dental practices in providing their annual self-declaration to CQC”
- 1 respondent replied “Although we agree there is a role for self-assessment in order to ensure minimum care standards across primary care dental services, this model must be provided alongside inspections. In terms of the information provided through the annual self-declaration, we understand that some practices already use a template in preparation for mock inspections and would highly recommend using something similar. We strongly agree with a collaborative model of regulation and believe the establishment of the Tripartite Programme Board is a good step forwards. In addition, the information gathered when practices are assessed by post-graduate deaneries as part of their application to become training practices, could also be shared with the CQC”

Respondents who answered “make better use of information from our partners, suggested the following sources of information:

- GDClocal Primary care trusts
- BSA annual reports
- Local Area Teams and dental data from NHSBSA.
- Commissioners and patients to understand which practices are 'higher' risk practices.
- Any highlighted concerns from pharmacy, hospitals, ambulances, LTA
- In addition to partner organisations mentioned in the consultation document you will find a number of local authorities have specialist dental infection control nurses who can provide expertise and information on local
- At no point do you mention the BDA Good Practice Scheme or other similar schemes. These are quite tough to remain current with and surely knowing a practice is a member is useful information.
- Information about best practice – publicise to all practices
- Regular meetings with NHS England regarding those registrants with an NHS contract. Use NHS Choices feedback.
- Denplan Excel data from their own inspections and from the regular patient satisfaction reviews that are done



- A joined up approach is essential. The recently revised sub regions such as the Central Midlands have a great deal of information about individual practices but don't now have the manpower and this is only going to get worse given the expectation of further efficiency savings. sharing of information and this information being used effectively and intelligently should allow recognition of practices that are potentially putting patients at risk.

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?

Of the 99 respondents who replied to this question, 85 respondents thought this would be an effective approach. Six respondents added additional comments:

Healthcare Professionals

- You need information from patient interviews and examinations.
- Involvement of specialist dental infection control nurses in local authorities
- Also further update CPD training certificates. Some practices excel in training needs and updating staff and others are not supportive, therefore many staff are falling behind on essential update information and skills. This in turn puts patients at risk.

Commissioner of Services

- Greater patient feedback and if possible staff

Providers of Services

- Yes, but as mentioned, the LDC could be a good source of information also.
- But only if the CQC inspectors adhere to the approach and send the requests to the providers.

12 respondents (9 Healthcare Professionals, 2 Providers of Services and 1 Member of the Public) did not think this would be an effective approach. They gave the following reasons:

Healthcare Professionals

- The CQC needs to show it is truly independent and not a tool to be misused by LATs
- Great, giving notice is a great way to find out what is REALLY going on, NOT!



- Difficult to answer as unclear what intelligence will be provided , especially re none NHS practices.- again cannot put in comment unless answer NO
- By and large they have no idea about treatment standards since the demise of the DRO. The people you really need to find tend to operate under the radar as long as their figures vaguely make sense.
- Paper exercise does not look at clinical quality
- I'm not sure that this will help you more than your inspections themselves so may be a waste of time money and effort
- This approach is almost the same as telling students what questions will be asked in a test so that they can spot and set only certain areas. The approach you offer means that there is no guarantee that practices comply in all aspects at all times

Providers of Services

- Anybody can "fudge" it. We hate the CQC and do not want to cooperate as it is a complete waste of our time.
- The people who don't follow regulations fully will prepare a glossy set of info you have requested. turn up cold and inspect any aspect you want to without the practice preparing for your visit

1 Voluntary and Community Sector Representative neither agreed nor disagreed but commented:

- What happens if the requested information isn't returned within the 5 days!

1 Professional Body neither agreed nor disagreed but commented:

- The consultation makes clear how it will obtain information from NHS bodies prior to an inspection and it suggests that the CQC is investigating what comparable information it might use for providers without an NHS contract. What progress has been made on this and, in the meantime, will those practices without an NHS contract be regarded as higher risk, despite having been inspected under the current regime? There is reference to making better use of shared intelligence and take a collaborative approach to monitor standards. We would be pleased to resume discussions about the practice information gained via our Good Practice Scheme.
- In addition, concern has been raised about notifying local area teams and HealthWatch ahead of an inspection, since this could easily lead to a number pre-CQC inspections, which would disrupt the practice and the service delivery. The letters might say it is a notification of an impending CQC inspection and ask these organisations not to undertake an inspection at this stage.



Respondents suggested the following ways of gathering pre-inspection information about services that do not have an NHS contract:

The top five themes are shown in the table below, followed by example quotes

Gathering Pre-inspection Information - Main Themes	Healthcare Professionals	Providers of Services	Other	Total
From practices themselves. Self-assessment. Send forms/ proformas well before the visit	8	5	3	16
Patients. Interviews/ surveys/ web comments/complaints log	7	3	2	12
Same way as NHS does	3	5	1	9
Work with dental plan companies	3			3
Speak to the GDC/BDA	1	3		4

Healthcare Professionals

- Ask them for info as you suggest.
- These need to be approached in the same way.
- Work in cooperation with the dental plan companies
- Check list of information required sent well in advance and practice given time to collate this.
- Patient surveys. Staff surveys
- Patient interviews and examinations
- Speak to the GDC , to see if any investigations have occurred.
- The exact same way as an NHS ran service, if consistency is the underpinnings of the CQC inspections they must be conducted in the same manner throughout.
- Self-assessment.
- From practices themselves.
- I would suggest you ask the provider for a more detailed self-declaration.
- What powers do the regulations give you to do this? That is your answer.
- Private services are still required to complete audits and should be able to send completed audit reports prior to inspections.



- if the practice has a website that allows comments to be left - you could see patients comments prior to a visit or if the practice has self-assessed their service previously you could request a copy of this.

Providers of Services

- Practice websites, GDC, pt complaints.
- You don't. This is not a police state or a communist country.
- Give due notice to the practice in a fixed time frame before the inspection i.e. 1-3 months before, to supply the information required.
- Ask for a sample of Patient satisfaction surveys or set up a web based questionnaires that patients can fill in at their leisure.
- Same way as an NHS contract.
- Speaking with the patients of the practice.
- Provide a consultation form where mandatory questions are asked about regulations and polices within the practice.

Member of Public

- Write to them
- By looking at other providers, who do YOU go to? Who do your family and friends use? What information is already available?

Commissioner of Services

- Advertise that an assessment will be carried out in local media (for NHS and non-NHS) so patients can provide feedback.

Stakeholder

- Require practice to post information on their premises, websites etc allowing feedback for at least an 8 week period. Check the regulators or complaints\concern handlers for the service and where available corporate records.

Professional Body

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

One healthcare professional argued that gathering such pre-inspection information would not be possible.



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**
- **No response**

Of the 98 respondent who replied, 30 said in the weeks before the inspection, 18 said annually and 49 said annually but with the opportunity for providers to update at any time.

1 Professional Body replied “If providers were required to provide an annual self-declaration, it would seem appropriate to request the information required as part of the inspection in the weeks before the inspection”

8. We have described the ways in which we could gather the views of patients.

Are there any other ways to gather views about the quality and safety of primary care dental providers?

52 respondents replied to this question and gave a wide range of suggestions. The most prevalent were to ask the patients (15 respondents) and to ask the staff (6 respondents). Respondent quotes include:

Healthcare Professionals

- Examine open source information - google and choices
- Look at the patient numbers. Good practices are often have large patient lists
- There is NO way you can find this out. There is NO way you can find out if I am a sound dentist or a dangerous one.
- On line forums and information gathering events i an area-perhaps with some CPD included and a bit of supper-say for 1-2 hours on a mid-week evening
- Patient interviews before and after dental examination by a qualified dentist.



- Views from the Dental team including the ability to view annual professional development reviews from each staff member as this may flag up weaknesses within the delivery of that particular service.
- OBSERVATION during the inspection by a qualified specialist adviser. I as could they , could weed out an inadequate practice within 20 minutes of visiting it when working and observing what goes on.
- Good practice scheme memberships. BDA, denplan and so on.
- Make the public aware that they can give direct feedback about a dental surgery via some kind of public website that is easy to use. They also need to be made aware of what they are entitled to when seeing an NHS dentist and the charges involved. I see a lot of patients who desperately need to see a hygienist but say their NHS dentist does not provide that service??
- Whatever information is chosen, the analysis of the data especially the sample size is vital. too often in the past conclusions have been drawn on the basis of very small sample sizes. The DAF reports (when available) are an example of a very effective contract monitoring tool but the lack of individual performer transparency is an issue. The vast majority of practice owners want to deliver a safe and effective service that meets the needs of their patients and builds on and maintains the practice for the future. Whilst practices have been criticised over their monitoring of the effectiveness of their services a lack of sharing of critical information and at an early stage has added to this. Combined with the lack of transparency around the NHS contract and what it should actually provide this leads to confusion for both patients and dentists. this has undoubtedly added to the level of complaints and the rise in these being made to the regulator.

Providers of Services

- Patients can be prejudiced in their views. I find it despicable that you want to try and bring dentists down.
- Local Area Teams
- Providers could be asked on how quality and safety are carried out and what policies and regulations are followed to maintain this.
- Having a dental expert (dentist) as a part of inspection team.
- Directly from the patients at the specific dental practice, chosen randomly.

Member of the Public

- Ask other patients
- No

Commissioner of Services



- NHS Choices feedback, number of complaints received by practice (or NHS England), GDC concerns

Stakeholder

- Local publicity including those who use the practice inviting feedback via easy and anonymous routes

Professional Bodies

- CQC could make use of other stakeholders' information – for example, the BDA's Good Practice and Denplan's "Excel" schemes contain a wide range of information about a large number of practices. Both organisations have said that – subject to the dentists' permission – this information can be shared.
- As stated earlier, other organisations which regulatory and oversight responsibilities, may have invaluable information regarding local primary care dental providers. It may also be helpful to identify organisations representing vulnerable groups and care providers to ask for feedback on local dental services. A recent survey of care homes in the region highlighted serious patient safeguarding concerns (dentists not changing gloves between patients, treatment provided without appropriate consent etc.). The CQC may also wish to seek views using other communication sources such as social media, whilst bearing in mind the limitations of such sources.
- We are keen to work with the CQC to define what 'quality' is before they start to try to measure it. This measurement of quality must be expressed in a way that patients will understand and that also has professional credibility. We also recommend that qualitative and quantitative outcome measures should be used to gather additional views about the quality and safety of primary care dental providers. This could include Patient Reported Outcome Measures (PROMS); Patient Reported Experience Measures (PREMS); and clinical factors such as longevity of restorations or Peer Assessment Rating (PAR) scores (orthodontics). As FGDP have stated in their response, whilst the CQC does not operate outwith England, it is worth noting that the other UK countries have good systems in place for monitoring NHS treatments via analysis of claim forms (eg, the GP17 in Scotland). Data relating to Units of Dental Activity may be helpful, such as failure to meet targets. The CQC may also find it helpful to look at



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?

Of the 101 respondents who replied to this question, 81 agreed with this approach with 5 respondents commenting further:

Healthcare Professionals

- It is important that the inspector has some dental knowledge and all inspectors are trained to ensure fair inspections across the board
- But there needs to be sufficient expertise in the team to ask relevant questions (and to enquire further if answers are vague), including those in my field of radiation protection.
- BUT the inspection team makeup should be passed to the practice prior to inspection with a valid explanation of why the team is so structured.

Professional Bodies

- In principle this would seem appropriate. We have reservations about inspections undertaken by specialists, however. These inspections have on occasion considered clinical activities of the providers – for example, the under-reporting of dental caries. This is not appropriate and challenges the CQC's commitment to ensure consistency, as the inclusion of specialists in the inspection team will be risk-led.
- The group was uncertain what the definition of a 'dental specialist' is? Is this a dentally qualified professional?
- Yes- but also needs to take into account the size of the premises, some locations will be extremely small and so a team of 3 could outnumber staff and patients combined- assume the size forms part of the risk method

20 respondents (11 Healthcare Professionals, 5 Providers of Services, 2 Members of the public, 1 Commissioner of Services and 1 Stakeholder) did not agree with this approach. The primary concern was that dentist cannot be effectively inspected by



someone without dental practice experience, preferably another dentist (9 respondents). Respondent quotes include:

Healthcare Professionals

- The length of the inspection (I note you are talking about 1 day) should be tailored to the size of the practice; a surgery practice with 3 members of staff will not require the same length of inspection as a 5 surgery practice with 3 receptions, 5 dentists and 15 support staff. Indeed, the smaller practice would view this as grossly unfair to them. Also, you already know that dental practices are the safest sector, so why not 3-4 hours as at present, why extend it to a whole day of surgery time (which will affect patient treatment)?
- Without someone with experience of dental practice the inspection is useless
- General practice should only be judged by General Dental Practitioners, not so-called specialists and certainly NOT by 'experts by experience'.
- Whatever you call a CQC person they are still there to inspect the practice and patients are aware of this please give them some credit - an expert by experience is an inspector under another name. All inspectors should be properly trained in what they are inspecting otherwise bias is introduced and fairness goes out of the window

Providers of Services

- Because there are no real risks to the public in dental surgeries.
- It should be based on how many chairs are in the practice
- Dentists should only be inspected by dentists
- It is not clear about "expert by experience" due to what i have heard from other provider!!!

Member of the Public

- Too complicated
- In my experience the more senior dentists attached to the practice do no NHS work, so it is more likely NHS patients' experiences are riskier and poorer quality because of this.

Stakeholder

- I have concerns that there may be issues that are under reported and there should be a way to bring some dental expertise to each inspection even if it is via advisors rather than direct inspection

Commissioner of Services



- There should be a minimum core group to include a relevant clinician (may be dental therapist or nurse dependent upon issues being reviewed) and then flexibility over and above this.

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

Do you agree with our mapping?

Of the 99 respondents who answered this question, 89 agreed with the mapping and 10 (7 healthcare professionals, 2 providers of services and a member of the public) did not.

Those who did not agree gave the following reasons:

Healthcare professionals

- You are trying to bend regulations for care homes and trying to apply it to dentistry
- It's blather
- It was fine the way it was. This is going to cause confusion and give opportunity for companies to make a lot of profit from the confusion. Lack of time and excessive paperwork will mean that a lot of practice owners will end up employing the services of these companies!
- It is very unclear, looks likely basically have altered the numbers of some of the regulations and added a bit about candour and fit and proper persons, which is probably in the existing regulations if you look hard enough or apply common sense.
- I think people can manipulate answers and skip on other areas.
- You have made it too complicated.
- It still is to generic and not service specific.

Provider of services

- Because it is a load of rubbish done by minnows in quangos trying to justify their existence.



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?

Of the 98 respondents who answered this question, 78 thought the questions would enable inspectors to judge whether or not a provider met regulations and 20 (10 healthcare professionals, 6 providers of services, 3 members of the public and 1 stakeholder) did not.

Those who did not think so gave the following reasons:

Healthcare Professionals

- Prompts not specific to dentistry
- You do not have the right people to inspect dental practices. If you did, they would not need prompts. You really are shooting yourselves in the foot with this survey.
- Too ambiguous and lacks consistency.
- Prompts are undoubtedly a good idea, especially for inspectors with no specific dental knowledge. However to infer that use of these prompts will enable a judgement of whether a provider meets the regulations is a leap too far. A provider can rehearse a set of answers to these which may bare no relation to their actual practice. Observation is the key factor and knowing what to look for unless you want a purely paper exercise which serves no useful purpose for patients.
- All answers to questions need an assessment of truthfulness of answers, they will help the inspectors to judge but not necessarily to fully "enable".
- By simply answering questions and ticking boxes - doesn't mean that all providers actually are following the "right" answers.
- Again it still is to generic and not service specific.

Provider of services

- Because they do not have my experience so cannot judge me. It is all a great big joke
- The inspector doesn't check the quality of dentistry counting folders full of paper won't tell you how good treatment is.



- Not always. It depends how the questions are presented; common sense and initiative will need to be used to. The questions could be guidance.
- It is not clear again, if the inspectors are fully familiar with the set of prompts, again based on what I have heard from other provider. If they are fully aware and understand these prompts and could be able to help providers to improve even more, then it will be very good. I have heard that different inspector have different views which make provider more confused.

Stakeholder

- Partially, fine overall but dental expertise and the ability to reach patients using the service a concern

Are the prompts relevant and do they ask the right questions?

Of the 48 respondents who answered this question, 29 said the prompts were relevant, 4 said they were not relevant and 15 commented further as follows:

Healthcare Professionals

- Yes, but experienced practitioner may be able to ascertain more accurate information
- It depends on the practice and the circumstances and the honesty of the answers provided. It is the interpretation of the responses and whether it ties in with what is observed that is key. For this you need specialist dental knowledge. Our inspector was from care homes and too frightened to observe patient interaction in the surgery despite our repeated invitation!
- The prompts must be slightly flexible on the day of inspection to the specific Practice that is visited, as some might have restrictions as to space or already fitted features that can't be altered.
- As before, a balanced and caring environment where patients are comfortable with the team is more important than box ticking. There must be a degree of practicality and some leeway. Generally, our experience has been very good, but - especially in the early days - others found some inspectors to be rule bound and inflexible. The prompts are a good way of teasing out the detail.

Provider of Services

- Yes but need to be considered in full
- As I said, different inspectors have sometimes different views, which could cause confusion.
- Yes, however, having been involved in part of the initial wave of the new model we have seen inspectors taking there questioning to a significant level



of detail, but their knowledge of the subject and their quoting of, in this case GDC standards, was out of date.

- They appear to be relevant however it all depends on whether they are executed well by inspecting persons

Member of the Public

- There should be weighting system for the various domains

Is there anything missing from the prompts?

Of the 35 respondents who replied to this question, 18 answered no. Respondent comments include:

Healthcare Professionals

- The starting point has to be the establishment of what type of practice is being inspected. Consistency has morphed into an assumption that one size fits all.
- Yes an expert to observe!
- Caring Service - are religious beliefs/ customs respected?
- Yes how good is your dentistry let me see it?
- Not sure if the answers can lead to accurate assumptions.
- Make sure your inspectors understand fully the different challenges faced by small vs large practices. One mould will not fit all.
- Far more qualification and CPD training in a variety of subject areas are needed for prompts

Providers of Services

- If you need prompts you should be on the stage.
- You might wish to look at the SDCEP website, where they have a combined practice inspection checklist that might be worth cross-referencing with your list.
- Just please ensure consistency from the inspectors - there has been too much variation on what is inspected depending on the inspectors background. There must be less interpretation and more 'this is what we want you to do to be compliant'.
- More on inclusion and communication.
- I don't think there is maybe the only thing would be the human touch towards the practice and its staff.
- Should be more provider orientated



- Expectations where multiple providers occupy one premises, how are the prompts relevant when the provider is not managing the service from the actual location i.e. has a HQ/HO at a different site

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?

Of the 99 respondents who answered this question, 81 felt confident that this would identify any areas of poor quality care with 2 Provider of services commenting further as follows:

- But please take into consideration the levels of patient care and clinical outcomes - that is what we are there for and what patients judge, patients don't care about the paper trail.
- Yes, but instances of poor quality need to be acted on!

18 respondents (9 Healthcare Professionals, 5 Providers of Services, 3 Members of the Public and 1 Commissioner of Services) did not feel confident that this would identify any areas of poor quality care and gave the following reasons:

Healthcare Professionals

- Yet again poor care would only be found by an expert in general dental practice. There is no possibility that a lay inspector could make valid clinical judgements
- Any sub-standard dentist will be able to hide any evidence from you, especially as you do not use GDPs. Only clinical examination of patients can identify this.
- If evidence is a piece of paper it will not identify poor quality care. Its absence may indicate that there is poor quality of care or that the emphasis in the practice is on actual care rather than paperwork or rehearsed answers.
- Unless a patient now takes legal action against a dentist, you have no real way of assessing the quality of the work. Many NHS practitioners will struggle to do good quality work within the fee scale. I am entirely private and I know that I can always the best job that I can based on what the patient consents to and can afford.



- Outcome measures may not show up as of good standard, or less so except over time. Therefore a retrospective look at outcomes should be considered.
- No inspection of completed work.

Providers of Services

- Because you cannot get things in perspective and the inspector I dealt with was a bully.
- CQC looks at the standard of care provision, but nothing looks at the quality of the clinical workmanship provided. This is a huge oversight.
- Nothing address the quality of instruments or materials which ultimately affect care E.g. cheap implants from China being placed in jaw bones.
- This will definitely provide some opportunities for poor quality of general care to be identified, however, how will the poor practice of dentistry itself be identified, without anyone examining the patients that have been treated (such was the role of the Dental Reference Officer previously), or with a non-dentally qualified individual carrying out the inspection?

Member of the Public

- How can practice managers validate the cleanliness of their premises when they don't know the level of micro-organisms on the many surfaces in their practice?

Commissioner of Services

- Additional evidence that staff employment requirements are met (e.g. CRB, qualifications etc.), equipment meets legislative requirements (not counterfeit), that cost of treatment is discussed with patients, that treatment plans are provided in writing or most appropriate format for that patients' needs, that staff understand how to gain consent from those who need more support (e.g. best practice), that patient views are acted upon not just gathered, that staff do not report feeling bullied or harassed, that there is evidence of learning within the practice team as part of a culture of reflection. To continue to review these as learning is gained.



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.

36 respondents commented, including the following:

Healthcare Professionals

- Most practices have little understanding of human rights
- There has to be an evaluation of the human rights of the dentists. Are they working under reasonable contracts that support their human rights?
- Politically correct crap that I cannot dignify by further comment.
- seems appropriate enough
- If evidence is a piece of paper it will not identify poor quality care. Its absence may indicate that there is poor quality of care or that the emphasis in the practice is on actual care rather than paperwork or rehearsed answers.
- I find impact assessments techniques not fully applicable to health services.
- Should already be doing this.
- This is an important part of the provision of care and I feel it is right that this continues to be monitored and highlighted.
- Annual update training should be a requirement as this subject changes constantly.
- I think they're both great ideas!
- Paper exercise that is of no value to me I agree human rights are very important but an IMPACT ANALYSIS what does this mean - it is garbage to most normal people

Providers of Services

- All ok provided adequately funded by the NHS!!!
- Seems appropriate enough
- I think care has to be taken to make sure that we are not over-regulated and inspected and that the inspections are not overly time consuming, and I worry that we will end up having to do even more paperwork than we already have.
- This does seem to mirror a practice version of the one we all should adhere to.
- Very difficult within different beliefs.
- It is included in practice policies.
- I think this is excellent.



- Blah blah blah whatever!

Professional Bodies

- We welcome the inclusion of the Regulatory impact assessment document as it provides an overview of the process to date and the reasons for and potential benefits of, the proposed revision to the inspection process. It also provides useful guidance on the direction of travel in terms of regulation. We also welcome the Equality and human rights duties impact analysis document as it provides clear, evidence based, guidance on the key areas for review and ongoing improvement.
- There is little doubt that any inspection of this nature will have a financial impact on the practice, including costs relating to any additional staff training and the time cost to the practice in complying with requirements (eg, gathering documentation in the appropriate format), in addition to the CQC fee itself. However, the proposals should help to support a broad improvement within the sector, and assist in helping providers to identify areas for improvement within their practice (notwithstanding the limitations on the number of practices to be inspected). We would highlight the omission of patient autonomy from within the regulations, which is fundamental for patient consent, as well as child and adult abuse issues within the Equality and Human Rights analysis.



4. Focus group responses

160 respondents in focus groups were asked what questions they think CQC should ask around the five key areas of safe, effective, caring, responsive and well led when CQC inspects a dental service.

16 of these responses were from young people aged 10 – 23, 4 were from parents/family carers and 5 were from support workers while the remaining 135 were from the Public Online Community.

Q1. What questions should inspectors be asking dental service providers under is it safe?

The groups proposed “safe” questions in three main areas

I. Hygiene and cleanliness

Young people and parents/ family carers

- Do they meet COSHH requirements?
- Is equipment clean and sterile?

Public Online Community

- How are the surgeries cleanliness standards maintained?
- Are all the instruments clean and tidy and are all staff wearing gloves at appropriate times?
- What are the procedures for keeping the dental tools and implements clean and germ free?
- Is all the equipment sterilised properly?
- Is the practice clean, neat and tidy?
- Are hygiene best practices in the safety policy?
- Are the equipment genuine and not going to harm patients
- How often are the areas cleaned with 'bacterial killing agents' and what evidence is there to monitor/record this?

II. Training, qualification and testing



- Do staff have relevant & up to date qualifications?
- Does it display up to date certificates and qualifications of the practitioners?
- Is the dentist/practice adhering to all set procedures and guidelines that have been set out by the inspectorate and can evidence of this be produced?
- Does it have the latest equipment and have testing for safety standards?
- Is the electrical equipment regularly tested and checked?
- Are all Dentist and Dental Hygienists qualified to a satisfactory level which is acceptable to the British Medical Council?
- Where do you buy your tools?
- How are you up to date with the new technology and safe practices?
- What would you do if the equipment stopped working in the middle of a treatment?
- How often do you have the equipment services?
- Has the dentist attended/ regular conferences to keep them up to date with all innovations
- First aid training up to date.

III. Patient experience

- What are the safety systems in place if a procedure goes wrong?
- What measures are in place to deal with emergencies such as heart attacks, is there a defibrillator in the practice and are staff suitably trained?
- Has the practice had any complaints from patients or threats of legal action after treatment?
- Have there been any recorded instances of a patient in your care suffering adverse effects after treatment at this practice?
- What steps do you take to ensure that details of patients' medical history are up to date?
- Are disabled patients able to access the practice easily and safely?
- How many complaints have been made each month?
- How do you keep your injections for freezing the gums, and at what temperature is your| fridge?
- Are injury logs maintained and incorporated into safety policy.
- Is the practice 'child safe'?
- Have you had any treatments that have gone wrong resulting in injury/hospitalisation?
- Are the staff and visitors of the dentist protected from all aspects of risk such as intruders, infection etc?
- Are patient outcomes in line with national averages?
- Is the building safe?



Q2. What questions should inspectors be asking dental service providers under is it effective?

The focus groups proposed the following “effective” questions:

Young people and parents/ family carers

- Is your treatment all done in one go?
- Can you access it when you need to?
- Enough time or are you rushed?

Public Online Community

- How long has each patient’s dental treatment been successful for? And by this I mean have any had to come back to your practice for follow up treatment for the same problem within six months after their first treatment?
- How many patients? How many types of procedures are practiced?
- Is the pain relief and sedative effective?
- Do you have documented proof of the effectiveness of your methods?
- Is the space provided used efficiently?
- How many complaints have they received in last year and how have they been recorded and acted upon
- How long do people have to wait for an appointment?
- Do you identify patients’ problem and rectify it quickly?
- Is the treatment you provide to each patient of an effective nature?
- Are patients concerns taken on board?
- Is there a guarantee on the work done e.g. crowns?
- How many patients are seen within 10 minutes of their appointment time?
- What is the longest waiting time for a patient to be seen?
- Are patient outcomes in line with national averages?
- Are patients contacted regularly?
- Does the dental practice receive a good rating by customers?
- Does it receive a high no of complaints?
- How do you decide that further investigation is required, e.g. x rays to detect underlying decay?
- Is the treatment given proactive or reactive?
- Is it cost effective, modern?
- Is there enough staff to deal with the amount of patients quickly and effectively?



- What is the rate of return of patients? (How many are regular attenders?)
- How does the dental health of the practice's patients compare with that locally or nationally?
- What links are there to hospital dental services when referral is needed?
- How well does patient recall work (reminders for check-ups etc.)?
- How does the practice deal with any language and/or cultural issues in a multicultural area?
- How frequently do patients return after an ineffective treatment?
- Do they use the latest proven techniques?
- Do you ask your patients for their views, both positive and negative? Do you review your practice in line with these views?
- How many remedial procedures are carried out?
- How many patients are registered in total and has this figure increased or decreased and why i.e. does the practice have loyal and happy patients?
- Does the practice carry out regular patient surveys and ask for feedback, suggestions and any ideas to improve the practice?

Additional areas of investigation suggested by respondents

- Budget analysis
- Staff wellbeing
- The historical data of the number of patients seen and any evidence of complaints.
- Efficient booking system, good communication

Q3. What questions should inspectors be asking dental service providers under is it caring?

The focus groups proposed the following “caring” questions:

Young People and parents/ family carers

- Do they pressurise young people into treatment?
- Are they respectful?
- Do they talk to young people in an appropriate manner?
- Does the dentist change their approach if you are with or without your parent?



Public Online Community

- What do the patients think?
- Are patients contacted to check that they are satisfied with the care that they have received? Are patient questionnaires sent out and recorded?
- Are premises and staff welcoming/friendly
- Care of nervous patients?
- What systems are in place to reassure patients?
- Are they understanding towards their patients
- Is a record of complaints kept?
- Do the nurses and dentists deal with you as a person with dignity
- Do they look their customers and give them care before, during and after their treatment?
- Does it have a wide age range of patients?
- Does the dentist/dental technician talk to you about the procedure that they may have to carry out?
- Will the prevention of possible future problems be discussed and advised upon?
- Does the Practice interact and advise parents of potential problems which their child/children may suffer in the future?
- Does the staff at the practice have up to date information about the client to enable them to interact in a friendly manner?
- How adaptable to less abled bodied patients is the surgery?
- Is there any special care for children, or patients with a phobia of dentists?
- What plans are in place for patient care in the result of accidents?
- What follow up process is used for patients after visits/check-ups, procedures?
- How would you deal with a patient who is completely nervous, anxious about visiting dentists?
- How do you explain any treatment required? Do you take time to explain why it is needed and any alternative options?
- What happens if a patient is scared of needles?
- How does the dental practice ensure that it complies with the needs of patients when discussing what treatment is best for them?
- Can they provide advice on diet and nutrition to help with dental care?
- Do they have an out of hours service?



- How long do you have to wait for an emergency appointment?
- Do you reach out to the community, schools, local groups, etc. to encourage and promote good dental health?
- Are patients offered payment plans where necessary?
- Does it take an interest in notifying the patients when they are due for a check-up?
- Does it contact patients to remind them of an appointment?
- How do you improve the service level over last few weeks?
- Are all options of treatment fully explained and offered.
- Do patients' views impact on your practice at all?
- Do patients influence anything your practice does? How?
- Do you offer a personalised service?
- Caring

Q4. What questions should inspectors be asking dental service providers under is it responsive?

The focus groups proposed the following “responsive” questions:

Young People and parents/ family carers

- If you are in pain does the professional respond to this?
- Do they respond to your needs, i.e. ignoring you if you want to speak to them alone?
- Can they make home visits?

Public Online Community

- Does the practice keep itself aware of changes to population and population make up to predict future requirements?
- Does it keep up to date with developments in dental good practice?
- Do you provide feedback forms (both paper and online) for patients to complete?
- Are the complaints responded to promptly & a file on each complaint assembled?
- How are issues for concern raised in customer feedback dealt with and how quickly? What procedures have been implemented to accommodate any previous? How quickly are customers seen/ referred on if needed? How are complaints dealt with and responded to?



- Do they deal with your queries and concerns as quickly as possible
- What is your procedure for establishing the urgency of the care required when you are contacted by someone with a dental problem?
- Can patients get an appointment within a reasonable amount of time, when in pain?
- Are records kept of patients concerns & the practices responses/actions?
- How are patient views and opinions heard?
- What is the Practice doing to ensure it is using the most current NHS approved treatments? Do you conduct client audits to ensure your current training and compliance is within NHS guidelines? Does this audit include attention to any complaint received and its on-going resolution?
- How quickly do you respond to patients enquiries via phone/e-mail or letter?
- Check with patients on site for accuracy in time booked to time seen
- How many appointments a day do you leave open for emergency treatments?
- How would you deal with a patient who believes they have an emergency but there are no available appointments left for that day?
- How do you deal with complaints and feedback?
- Do they have a list of out-of-hours treatment facilities if not provided on site?
- Have they got a comments card readily available to fill in satisfaction rates with treatment?
- Are their patients happy with the communication?
- Do you invite feedback from your patients?
- Do you have a clearly advertised complaints procedure?
- Do the practice follow up with patients who miss appointments
- What are some changes the clinic has introduced?
- What has the clinic improved?
- What does the clinic need to improve?
- Is there a quality assurance system in place?
- What are the opening hours?
- Do they offer late night, early morning or weekend appointments ie. out of normal working hours?
- Do you plans and actions for the effective day to day running of your dental practice work well? If not, what do you do to resolve matters immediately?



- Do you have a supply list actively available in case of staff sickness?
- Do you ask, respect and take on board patient and staff concerns?
- Do you always respond quickly to any questions a patient may have?
- Are cancellations offered?
- Is there an emergency phone number/helpline clearly displayed?
- Are telephone calls and letters/emails answered within set timescales?
- Does your practice respond to negative and positive feedback from patients?
- Is it a flexible service which is responsive to changing social patterns?
- Can the practice adapt to meet special needs of patients?
- How are nervous patients or autistic patients treated?
- Does the practice survey or invite feedback from patients and if so, what action is taken on the results of such consultation?
- How do they do fee calculations and forecasts?
- Is all the treatment given in an allocated time and understood?
- Do you monitor response times to calls?
- Does the practice explain everything thoroughly and answer all the patient's questions about the treatment?

Q5. What questions should inspectors be asking dental service providers under is it well-led?

The focus groups proposed the following “well lead” questions:

Young People and parents/ family carers

- Is it well organised?
- Do the staff know what to do? Is there a “plan of action” about what everyone should do?
- Who can patients go and speak to if they have a complaint?

Public Online Community

- Are there procedures and policies in place to ensure a consistent level of care across the practice? Is the practice leader visible to staff and patients. Are practices and procedures documented, monitored and audited?
- Is there a clear leadership and effective communication system?
- Is there a clear sense of direction?



- Is it carried out in a professional manner?
- Do you have regular staff reviews to give staff the opportunity to assess the management of the dental practice?
- Is the manager suitable for the position?
- Is one person responsible for the practices handling of complaints & a record kept of responses & follow up actions?
- Is it fully staffed, how is the staffing managed and how well? Are there regular one on ones with each staff member for issues/feedback to be given re management amongst other things? How well is the practice performing on feedback, ongoing issues not being dealt with first time
- Do the staff have a meeting every morning to discuss the running of the practice and given their instructions for the day
- Is the Management Team capable and well led?
- Is the lead clinician an effective leader?
- What is the leadership structure?
- Do you see the same dentist every time?
- Ask the staff in confidence how they rate their bosses and is there any issues
- Does the management delegate correctly but still maintains his/her role in a senior position dealing with issues that may arise which cannot be delegated.
- Ask how the staff feel they are listened to and any concerns acted on
- Is there a chain of command i.e. a management tree?
- What process is in place if certain people in the practice are unavailable/ held up?
- What is the general consensus of staff about leadership?
- Would it be possible to speak to some employees to get a quick insight re: how the practice in run?
- Do staff have 'safe' ways to bring up concerns?
- Do the management have full view of all activities and employees performance and behaviour?
- Is the practice committed to lifelong developments for their clinical and none clinical staff?
- How long does it take for the telephone to be answered?
- What payment methods do they accept?
- Do all the members of staff feel comfortable using channels to discuss the knowledge or concerns that they have.
- What evidence is available to demonstrate good leadership?



- How it has improve the process over the last few month and what are the new plans to improve the process going forward
- Can the management demonstrate adequate consultation/involvement with staff?
- Are all records up-to-date?
- Is management always looking at updating systems?
- Is staff training take seriously with records to prove it?
- Is dentist experienced and a member of dental association, are appointments run to time, and discuss what treatment options are available for patient? Do they fully discuss charges, benefits and disadvantages of different treatments e.g. dentures against implants etc.?
- What is your staff turnover like?
- good team, with regular meetings and workshops
- How does the dental surgeon keep up to date with what is going on in the surgery?

In addition, young people and their family/ carers were asked what they would want to see in a CQC report and what influenced their choice of dental practice.

The group would want to see reporting on the following areas:

- Cleanness
- Safety, minimal hazards
- Disability awareness
- How they work on the feedback / complaints from patients
- Feedback from patients, staff and management
- Undercover inspections

They suggested the information should be made available in a range of accessible formats, such as Braille, audio, easy-read.

Influences on young people and their family/ carers on choice of dental practice

- Venue accessibility - there is lack of accessible dentist services
- Patient choices – do they have a choice?
- Reception / entrance needs to be accessible, i.e. wheelchair ramps, lower front desks, no hazards.
- minimal stairs / lifts
- friendly / fun/ interesting



- want information in accessible formats
- loop system needed throughout to aid hearing
- Dentists need to have disability awareness and communication training
- not patronising
- be polite, friendly, being able to explain things clearly
- make eye contact, not staring at their computer all the time
- have proper training, practice and qualifications
- “talk to me, not parents.” Mostly they should talk to the YP directly, but for younger people it can be helpful to have parent there to make sure YP understands and is reassured.
- Be more gentle, communicating throughout. One YP said their dentist had gone ahead with a procedure even though it was painful, ignoring their unhappiness.
- Receptionists need awareness too and need to be friendly and respectful to YP.
- “I can see the same dentist.”
- They should be inspected regularly.



5. Observations from specific population groups

HIV + patients

Participants made the point that good dental hygiene was important to promote general overall health and to prevent infection, so access to dental care was important.

Issues to do with dentists were:

Access to dental care:

Not being able to find an NHS dentist

- Not knowing how to go about finding an NHS dentist
- One participant had only been able to access a dentist that was a long way away (two bus rides and a long walk)
- Dentists saying they are full when you mention HIV. Some dentists refuse to take people on their lists.

Concerns about disclosure of HIV+ status

- Given how hard it is to find an NHS dentist, some participants expressed concern that disclosure of status might result in them not being accepted on to a list
- Some participants said that they would not put down that they were HIV+ on the registration forms but preferred to disclose in person to the dentist when they went instead.
- One participant said that his status was clearly visible on a computer screen which could be read by people who were stood in the queue behind him at a practice in Pudsey.
- Another said that a receptionist had called out 'what HIV medication are you on' across a waiting room.
- One said that a nurse had called out about their status participant said that he had disclosed his status to the practice in Armley and had had no problems at all.

Being removed from dental lists

- One participant said that she was often ill because of her status and had been struck off under the 'two strikes and you're out rule'



- One participant said that after having been taken on they were told that they could not remain with the practice (in Church Street) because they needed too much work doing

Discussion of treatment

- One participant suffered badly with bleeding gums. The dental practice had told her that there was nothing that they could do for her, but she was concerned that she may just have been written off.

Homeless people in Derby

- Talked about the difficulty of getting a dentist if you are homeless.

People with a Learning disability said good practice among dentist is

- Being properly involved in decisions about treatment and being asked to give consent

People from other population groups said good practice among dentists is

- Being given explanations for delays in treatment or late running appointment
- Dentists are good at reminding people about treatments.
- Friendly receptionist
- Sympathetic dentist who take time and reassure you
- Check whether you are in pain
- Explaining how long the treatment will take
- Accompany the patient to the dentist's clinic
- Talking in simple, plain English.



6. Mumsnet forum

The following was posted on the mumsnet web forum:

The Care Quality Commission say: "We believe passionately that everyone in our society deserves safe, high quality, accessible dental care. To help ensure dental services (high street dentists and emergency out of hours services) are safe, effective, caring, responsive to people's needs and well-led, we are changing the way we regulate, inspect and rate dental care.

During an inspection, we look at premises, systems and processes, dental records and observe care being given. We also speak to patients and dental staff, to find out what they think about services being provided and identify any concerns, or best practice.

We want to hear your views on what good dental care looks like for you and your family, to help us decide which key areas we should focus on during our new style inspections, which will be finalised by April 2015."

So, what does good dental care look like for you? What is more important to you, in terms of dental care? Have you had any particularly good experiences of dental care in the past few years? Or have you had any particularly bad experiences? What would you like the CQC to look for when inspecting dental services? Is there anything in particular that you think could be done to improve dental care in general?

There were 112 responses on the forum.

The top themes among these respondents are represented by the table and example quotes below:



Mumsnet forum top themes	No. of respondents
1. Cost is too high/ unclear	15
2. Lack of access to NHS dentists	14
3. Always had a good experience with NHS/ like my dentist	13
4. Have to go private to get good care/ NHS care rudimentary/ NHS not fit for purpose but push expensive private treatments	13
5. Good information/ communication and explanation of procedures and options is important	10
6. Appointment availability is a problem/ the wait is too long	9
7. Poor provision for out of hours dentists	9

1. Cost

- It can cost upwards of £50 for a dentist visit around here and if you need to see a hygienist they are classed as private even though the dentist says you need to see them and that alone costs upwards of £43 on top of the visit cost and any treatment you need.
- We couldn't find an NHS dentist in the area so we had to go private. It's eye-wateringly expensive, and even costs for the children when they literally open their mouths for 30 seconds. Every time I go the waiting room is a bit plusher. The dental care is okay, but I don't feel like I can make informed decisions on my treatment. It's just "this is what you need: it's going to cost £650..."
- My dentist is pretty good but costs a fortune - £85 for a five minute check-up but I trust them so keep going.
- Dentist is nice enough but is £40 for a 5 minute check-up (no treatment whatsoever) really an acceptable charge? No wonder the nations teeth are going down the toilet....
- Im 35 and was advised to get braces on my teeth to correct my bite as my teeth were wearing down fast (not for vanity reasons). Because of my age this treatment wasn't available on the NHS so had my braces fitted privately. The cost was £1, 500 on fitting, then £1, 500 on removal. During treatment we hit hard times & our circumstances changed & couldn't afford to get the braces removed!. The private practice was completely unsympathetic & didn't give two hoots & my NHS dentist said they weren't allowed to touch them. I had no way of getting my hands on the money but luckily after someone mentioned



PALS to me, I got given the funding for my NHS dentist to remove them. All of this caused me so much distress & at the end of it I'm no better off as couldn't afford to keep up the treatment! Ludicrous!

- I was surprised that an appointment only seems to be a basic check-up and I can't get a scale and polish unless I visit the on-site private hygienist at £45 a visit. The dentist only does check-ups and any work which needs doing is seen as private treatment, which I find a bit bizarre.
- I am very happy with our NHS dentist; we have been with them for about 25 years and have always had good care. Between us we have all had major dentistry and in some cases have been referred to hospital which has also been a positive experience. The only issue I have with going to the dentist is the cost.
- Since joining a practice as an NHS patient I have seem to have spent a fortune. The costs are completely unclear as they do not seem to match the costs for the three levels of treatment on the NHS. I am considering going back to private again as it was cheaper.

2. Lack of access to NHS dentists

- We had many problems finding a dentist with spaces and had to wait several years until a new practice opened, so we do not really have any choice on which practice to use.
- I'm lucky to have found an NHS dentist - they are very few and far between in my area. My parents dentist has become private and everyone had to move onto denplan or leave, which is not ideal.
- It's almost impossible to find a NHS dentist around here where we live.
- Many clients often struggle to get an NHS dentist that provides a really good service
- In my parents area, they can't get on an NHS list.
- At the nearest NHS surgery, I was told the waiting list was 8 months! I ended up having to register with a practice 25 minutes' drive away (we live on the edge of a big city, there are at least 30-40 dental practices closer to us but NONE of them take new NHS patients).
- I can't even get my children / myself registered with a dentist in my area.
- Being able to find an NHS dentist would be nice, there are none taking on adults in my area.
- Getting a dentist in the first place. Which is practically impossible round here.
- We go to a private dentist, and always have. NHS dentists in SW London are like hen's teeth.



3. Good experience with dentist

- Our family dentist has been treating me since I was a baby and now is doing the same for DD and DS. He is brilliant, in that he "checks" their mouths every visit even when they had no teeth, just so they could get used to the process. He also, talks me through everything he does. So for example, he explained every step when he was doing a filling. He has taken the time to find out that this reassures me. He is also very friendly and notes little pleasantries that he brings up next time we are in. It is a very personal service.
- I really like my Dentist. She is young with a friendly attitude and always takes the time to ask how I am in an interested fashion.
- I loved my NHS dentist. She was friendly, honest, clear about her skills and where they were limited to my condition (periodontal disease which is very aggressive), I had to have a lot of treatment including having a very tricky filling done, I was having to bring my under one with me as I didn't have anyone to look after him. During one trip my DS was getting very distressed and the dentist suggested I feed him while she finished. The relief at having a dentist supportive of breastfeeding enough to finish off a filling while her patient breastfeed.
- I am very happy with our NHS dentist; we have been with them for about 25 years and have always had good care. Between us we have all had major dentistry and in some cases have been referred to hospital which has also been a positive experience. The only issue I have with going to the dentist is the cost.
- I'm very happy with the care received for all my family. We are quite fortunate I think in that there are always openings in our NHS provider.
- We have a great family dentist and have no complaints whatsoever about the practice.
- Generally my family's NHS dental care has been good.
- Our dentist is such a lovely man, all the family go to him, he always explains everything carefully in a way we can understand, he is fast and very gentle when carrying out work that needs doing. I used to be scared of the dentist, but not anymore. He is an NHS dentist and I was lucky to get us on their list!
- My dentist is fab, send text messages day before to remind you of upcoming appointments. Have bright airy waiting rooms and super staff. I might have to travel 8 miles to get there as was nearest NHS dentist taking on patients about 10 years ago but sure glad I did.

4. NHS dentists not fit for purpose/ have to go private



- Given NHS England's very hands off approach to dental performance or quality management - which basically means that complaints are batted back to the practice and they have no PALS function to record, monitor and act on low level concerns before they escalate AND the inability of the GDC to respond to issues bordering on negligence when it comes to patient safety, where does the CQC think you can or should go when you know for a fact that the dental practice is in breach of their contract, has done an inadequate job of maintaining your oral health BUT you need to have access to an NHS dentist? Who is actually making sure that tax payers are getting what they are paying through the nose for?
- It's like 'Rogue Traders' out there!
After years of bad dentists, I've finally found one I trust.
- I think realistically NHS dentistry does not exist beyond check-ups and extractions these days. If you need any real treatment and you don't want materials used that are banned in most countries then you have to pay.
- When my husband asked one dentist what's the difference between the private and NHS crown, the dentist said "the private one won't fall out".
Actually my husband was in pain and unwell a lot of last winter with tooth problems not being sorted properly- abscess, antibiotics etc.
- CQC what do these tales tell you about NHS dentistry?
- Perhaps you could pass it on that the DoH lie to the public about dentistry and as a result people have unrealistic expectations of a service that's not fit for purpose.
- I've had a mixture of good and bad but generally have had to go private to get good care.
- I can't speak strongly enough how upset and disgusted I am where dental health has ended up. Making it a paid for service has ruined it. I have spent years, and wasted good teeth avoiding going.
- I used to go NHS but the service was awful! The staff were rude and unhelpful to all of the family. My local private practice is much better.

5. Information/ communication

- Ability to communicate clearly with patients should be a basic.
- Our family dentist is the local University practice. Distinctly no-frills, however, we appreciate the personal care from the dentist who always takes the time to explain any outstanding issues and treatment options if applicable. This is very important to me as I feel 100% confident that I can make an informed decision about treatment for myself and my kids.
- Our family dentist explained every step when he was doing a filling. He has taken the time to find out that this reassures me.



- I'd like to see good patient information. Individually prepared (not detailed but just a survey) which targets actions patients can take to maintain their own health.
- I like it when the dentist has read your notes before calling you into the room, and then checks with you what you think they are doing at this appointment. It might seem like a small thing. But it's worrying when they just get started finishing off something that a different dentist started, without checking first.
- Our current dentist is great, young and very friendly. We have a quick chat before heading into the chair, which always puts me at ease.

6. Appointment availability

- After I broke a tooth I managed to get an NHS emergency appointment quickly. However, they wouldn't do any treatment at that appointment and I was going to have to wait another 4 weeks to actually have anything done about it!
- I would go private by preference- it's not such a nightmare. I called one for NHS dentist an appointment and they gave a date 4 months later with a time.
- They are constantly cancelling my appointments, 3 times last year & I had to wait over a month for an emergency appointment which they then cancelled again & it was another 3 weeks till the next one
- My personal main concern is the ease of getting a convenient appointment, especially if I should develop toothache or other problems, being able to get it treated quickly.

7. Out of hours service

- There is a very poor provision for out of hours dentist cover. The hours are restricted & places for appointments few.
- Out of hours care is patchy at best and completely inadequate at worst. Patients shouldn't have to go to a&e to obtain adequate pain relief or antibiotics.
- 24 hour emergency cover should be basic. It's appalling that patients are left in awful pain because 'the dentist isn't open yet', or that A and E can only supply painkillers until they are.
- If you have awful pain you can get emergency treatment, unless it's teeth, in which case, tough?
- The only issue I have had with dental treatment for the children is out of hours care. My son broke a tooth quite badly over a bank holiday weekend a few years back and it was a nightmare to get sorted out (he ended up under a GA to have it extracted about 6 weeks later.
- There is virtually no NHS dentist cover out of hours!



- I had a great experience with an out of hours service but it was very hard to find them. Out of hours needs to be organised better. Every hospital should have a dentist, not many do, even when NHS direct send you there.



7. Written submissions

1. Local Dental Committee

The submission addressed 4 issues as they relate to dental care

:

Best Practise

- Best practice in one area doesn't necessarily translate to best practise in other areas
- May be considered unjust to judge newly qualified dentists by best practise standards which may require specialised knowledge – even newly qualified dentists have a wide range of interests and skill sets which they develop throughout their careers
- Patients are all unique. They have different: dental and social needs, Motivations, anxiety levels, physical and mental abilities, financial constraints etc. We need to account for these, and potentially other factors.

How setting standards of best practice may drive down quality of dental care

- Dentistry is not a free market economy because of the impact of central government directly with regulation and also via the NHS.
- NHS practices have fixed price dental service. To try and force the provision of high service and high quality will lead to the failure of businesses who do.
- Much of the “best practice” we have heard proposed prior to this meeting constitutes improved service measures
- In increasing the measures of service, without increasing price there will be the unintended outcome of forcing down quality as businesses struggle to survive.

With reference to the Health and social care act 2008

- The CQC is empowered to ensure standards of quality and service are met. This is currently being done with a tick and cross being shown in reports.
- The CQC does not have a legal remit to be rating dental practices, rather it is to judge if a dental practice is meeting legal minimum standards



- Dental practices will have their clinical treatment judged on non-clinical criteria, such as service criteria if a ratings system is introduced. These criteria are not representative of clinical care
- Different practices provided different services and need to be able to be responsive to the needs of their patients with different skills and approaches to patient care
- It is impossible to have all skills and all equipment at any practice
- Simply judging if equipment is present in a practice does not represent that it
 - i. Is being used
 - ii. Staff are trained and competent at using it.

Judging Clinical treatment

- When assessing undergraduate dentists, a variety of methods are used. The commonest, and most effective is assessing their treatment during and afterwards by a qualified dentist.
- If there is a method of assessing clinical treatment without looking at the work done dental schools would happily embrace it. However for patient safety and efficacy it is essential for a qualified dentist to review the treatment provided.
- Whilst non-clinical evidence may be used as indicators of quality and service the need for a dentist to assess the overall situation with a patient in terms of the quality of the care is the correct approach. This allows discussion with the patient and assessment of their overall holistic needs.

2. Local Dental Committee

- The purpose of NHS Primary Care Dental Services is to provide safe, effective, compassionate, timely, high quality care that is responsive to people's needs. Services are peer reviewed and continuously improved within the resources made available. NHS dental resources over the past decade have been reduced from around 3% of NHS expenditure to nearer 2%.
- In light of this we are encouraged by your general observation that NHS Primary Care Dental Services manage to provide good quality care and represent a low risk to patient safety. We agree that inspection should be accordingly proportionate and respectively suggest that CQC inspect no more than 5% of practices a year rather than the 10% proposed



- Most of your inspections will be carried out by a single inspector on a single day. You do not clarify the qualifications, training or experience required of the inspector. As the inspector will be making judgements about the Practice and its Practitioners, WLDC takes the view that he/she should be a practicing NHS dentist or as a minimum a qualified dental professional with recent primary care experience
- WLDC also takes the view that no CQC report, or findings, or ratings should be published without allowing the Practice 20 working days to correct factual inaccuracies and to challenge unsubstantiated judgements. Following which, if the report is not amended to take account of legitimate, evidenced representations, the Practice should have the right to appeal to senior CQC management. Publication should be withheld until the appeal has been resolved
- In the interests of producing a balanced report the CQC is urged to seek information from patients who enjoy a good experience as well as about complaints. WLDC takes the view that the inspection should not just provide an opportunity for those who may have concerns

3. Professional Body (consumer rights)

Recommendations to CQC

As a result of our research, CQC should fully implement the recommendations made by the OFT in 2012.

The OFT recommended CQC expand the focus of its inspections of dental practices to routinely include specific assessment of whether dental practices consistently provide patients receiving both NHS and private treatment with:

- Timely information on the dental treatment they are to receive, including the cost of the dental treatment
- A written treatment plan which clearly and accurately sets out the dental treatment(s) to be provided, whether each element of the course of treatment is NHS or private, and the cost of each individual element of the course of treatment.

In order to properly respond to the OFT's recommendations, we recommend that:

- In developing their new methodology for inspecting dental providers, CQC should ensure that inspectors look for evidence that providers are



consistently displaying price lists and providing eligible patients with treatment plans

- Where inspectors identify providers that are not fulfilling these requirements, they should take enforcement action and follow up with them at a later date to ensure changes have been made.
- As they have done for GPs and acute providers, CQC should develop Intelligent Monitoring for the dental sector. This would enable it to make use of real-time feedback to identify practices where there might be particular issues and then prioritise services for inspection, or provide this information to NHS England Area Teams to assist with contract management of providers.



8. Speakout groups

There were 32 speakout group attendees in total as follows:

- 10 from Al Hayat Men's Group
- 8 from Cornwall People First People with Learning Disabilities
- 4 Refugees and asylum seekers
- 6 from Sifa Fireside
- 4 from Derbyshire Gypsy Liaison Group

1. Have you heard of CQC?

28 respondents answered this question.

18 had heard of CQC:

- 6 from Al Hayat Men's Group
- 6 from Cornwall People First People with Learning Disabilities
- 2 from Sifa Fireside
- 4 from Derbyshire Gypsy Liaison Group

2. What makes good dental practice?

The top themes are shown in the table below, followed by example quotes:

What makes good dental practice?	No. of respondents
Access to dentists/ appointments	11
Information and communications	9
Bad experience at the dentist	8
Reception/ staff	8
Qualification/ trust in expertise	7
Lateness	7



Access to dentists/ appointments

- For me the most important thing is being able to access a dentist. I'm not bothered about ratings! Obviously I would be concerned if the dental surgery is not clean or if I had to wait longer than expected but I could live with that. My main priority is that I am able to see the dentist when I need to!
- Access to NHS dentists is a big issue – most of them are full! For many people registering with an NHS dentist is very difficult! If you need emergency treatment this can be almost impossible.
- My daughter had to change her dentist and found it very hard to find one that would take on NHS patients. It took her 18 months.
- That you can get access to an NHS dentist. That the process for getting a dentist is simple.
- My own dentist is in Saltash but getting an appointment can be difficult. It can take up to 2 weeks! I was in pain and really struggling and had to wait 2 weeks to see the dentist. After the dentist had checked me he told me I had an abscess and referred me to a specialist in Truro. My mum had to drive me there. It took us two hours to find the practise. I was really irritated with my own dentist because he had no consideration that I had a learning disability and couldn't have gone to Truro without my mum. Dentists should be more considerate and empathetic – they should think about access issues; especially if you have to make a long journey very early in the morning.
- There is only one dentist in Saltash and it is very hard to get an urgent appointment as they get so booked up. If you are not already registered you won't get on.
- I have to catch three buses to get to my dentist as I can't get onto the register of one local to me – get nervous sometimes.
- Having to wait too long for appointments
- We have to travel too far to the dentist
- Finding a dentist and getting registered is very hard
- Appointments can take up to 4 weeks – it's far too long

Information and communication

- That you have access to an interpreter if you need one
- That sensitive information is requested and handled properly and confidentially. For example, being asked about your HIV status on a form that you fill in the reception area when you are not sure who will see it is wrong. You don't mind telling the dentist in person, but you don't want everyone to know.



- There should be information available about emergency out of hours care.
- I always used to get anxious about going to the dentist. I worry about my throat. My current dentist is a young graduate. She's very nice. She made time for me and explained everything in a very down to earth manner. I felt very comfortable and at ease. When she did the procedure she talked to me and explained each step; even what the filling was made of. It took my mind off things because I knew exactly what was going on. She treated me with dignity and respect. Communication is vital.
- Communication is a big issue – staff don't know how to communicate with people with learning disabilities. Family members struggle with information. The information should be more accessible – easy read; more visual – pictures and images.
- My dentist is not very good at communicating changes to the way they do things/management or appointment arrangements.
- My dentist always sends me a text and a voicemail reminder. That's really helpful.
- My dentist always explains to me what he's going to do.
- I like it when they talk to me about what they are going to do.

Bad experience of the dentist

- My young granddaughter had a terrible experience at the dentist's. She needed a filling and was very worried what would happen at the dentist - so my daughter sat her down and explained that she wouldn't feel the pain because the dentist would numb her by giving her an injection. But the dentist started the filling without giving her anything. When my daughter asked why she wasn't given anything; the dentist replied: *'We don't do needles!* 'My granddaughter was squirming in pain and the dentist instead of reassuring her said to her: *'I've never had a patient like you before!'* . That's not how you speak to the patient. The dentist should be sympathetic – they should have good communication skill but they feel they don't have to tell you anything!
- We had the same dentist for years and when he retired we had to find another dentist. I joined a practise but didn't go for about 15 months. I received a letter from them to say they had struck me off. They never sent me a reminder otherwise I would have gone.
- I'm terrified of going to the dentist. I had a very bad experience once – I had to have stitches in my mouth but it got infected and I was in terrible pain. I had to go to the dentist everyday to get cleaned up.



- My niece had some dental work done and had an allergic reaction – she collapsed and was rushed to hospital. We were shocked because the dentist didn't tell us this would happen.
- I've also had a bad experience with the dentist. I had tooth ache and went to the dentist. He took an x-ray and told me that I had an abscess and the tooth needed to come out which would take about 15 minutes. I had my two young children with me and had to leave them with the receptionist (who was great). It took the dentist 50 minutes to remove the tooth. Afterwards, he gave me a prescription for antibiotics. When I got home I remember putting the children in the playpen and completely knocked out. When I got up I was in so much pain that I had to go to A&E to get myself checked out. The aftercare was really bad!
- As a child I had a bad dental experience which put me off for life. I know I need to go to a dentist but would never go because of that experience. A good practise should help patients like me.
- My own experience is quite poor. I went for a filling and was told I had an abscess and should have my tooth taken out straight away. The dentist started to take the tooth out but couldn't. She was struggling. In the end she had to go for 10 minute rest but left half the tooth hanging out. It took her an hour to take my tooth out. I went home and that night I was very poorly. The bleeding wouldn't stop; my mouth was swollen. I went back the next day and she gave me a prescription. I took it to the pharmacy and they told me she hadn't signed the prescription. So I had to go back to the dentist and get it signed again. She never even said sorry.
- One of our service users had all his teeth removed about 2 years ago and has never had a follow up. He still has no teeth!

Reception staff

- That reception staff are friendly and know what they are doing
- Good reception staff. Most of them are quite informal. They don't even smile!
- Staff should be accommodating and make you feel comfortable. I get irritated if I feel they are dismissing me
- All the staff should be good to talk to and treat you with respect. They should explain things well/simple. They should not just speak to the support worker.
- The receptionists are not friendly at all. They don't communicate with you. Quite surly
- Welcoming atmosphere – premises and staff



- I agree the receptionists can be a barrier – when they book your appointment they never ask if you've got any mobility other needs! They should be more sensitive.
- Some staff (receptionists) tend to talk down to you. When I have been to the dentist they speak to my support worker and not to me. They also give information to my support worker and not to me. I am just ignored, yet I am the one receiving the treatment

Properly qualified/ trust in expertise

- It's important that staff are properly qualified and are working towards professional guidelines – including temporary and locum staff.
- Would like to see a certificate of quality or a plaque – this would help to build confidence
- Qualification of the practitioners – are they appropriate and up to date?
- That staff are competent.
- I agree, you're putting yourself in their hands; and trust they are skilled at what they're doing! Trust is a very important factor.
- Some of the new dentists are not that experienced. I went to a new one and he couldn't take my tooth out - he was struggling; he was sweating and started to panic which made me very nervous! I was shocked!
- All the good dentists have gone abroad – we are getting more and more from overseas – the inspectors need to check if they are trained and qualified to the same standards as the English ones!

Lateness

- My experience of dentists in Halifax is that they are always running late. For me punctuality is top of the list. I always end up waiting at least an hour, sometimes an hour and half for my appointment
- I agree I've also had to wait for more than an hour on several occasions but when I complained they took me off their list.
- If you have to wait they should tell you it is because the patient before you is taking longer than dentist thought. Otherwise you get worried and might leave. I'm always too scared to ask.
- That you are seen on time
- I think its common courtesy the dentist informs you if they are running late. Similarly, they should let you know about your treatment plan and costs before they start any work.
- If the dentist is late they should tell you why there's a delay.



- If you arrive late the dentists won't see you – but if they are running late they make wait without an apology.

Cleanliness

- I've never seen my dentist washing his hands – I would like to ask him to wash his hands in front of me.
- Personal hygiene's very important . My old dentist used to smell – he had a strong body odour – I felt like asking him if how many times he had a shower.
- We heard on the news about a local dentist who hadn't been changing his gloves! That's not right! Hygiene should be top of the list. The patient should feel confident that the dentist is clean. The Inspectors should ask them how often they change their gloves – including the dental nurse.
- My dentist's a lovely man; but every time I go for treatment I end up getting ulcers. I feel like asking him '*are you clean - has the equipment been sterilised?*' I would feel better if they unwrapped the equipment in front of me.
- I agree, you see the staff unwrap equipment in hospitals – and know its sterile - why can't the dentists do the same? I would feel confident if they did this.
- Cleanliness

Other key issues included:

Awareness of standards/ ratings/ complaints procedures

- There should be information about 'standards of care' at the surgery. If you purchase a loaf of bread you know what you're going to buy and how much it is – it should be the same for dental treatments - it shouldn't come as a surprise!"
- "I didn't know there were any standards for dentists – that's why it's difficult for me to gauge and tell you if a service is good or bad. The dentist's should be providing this information to every patient they see and asking for feedback after their treatment is completed."
- "CQC should raise public awareness about standards and ratings. By coming out and talking to us is a good thing and one way of raising awareness."
- If the patient doesn't know what the Govt standards are - they can't rate that service. CQC should be telling the public and patients about standards and what people should expect.



- I agree, the public needs information on standards and ratings to help choose a dental practise.
- I think there are lots of people who are dissatisfied with their dentist and want to complain but don't know how to.

Emergency dental care

- If you need emergency dental treatment they send you to Huddersfield – which is miles away. If you haven't got transport you can't access emergency services.
- If the dentist is closed and you ring 111 they send you to A&E. Why can't the GP and dentists surgeries all be located in the same building or at least close by?
- I wanted an emergency appointment but it wasn't treated as an emergency even though my tooth was cracked and the root was showing I was in a lot of pain. I had to go to the hospital to be treated
- I had severe toothache. My mum phoned the dentist and we got an appointment the next day – but we had to go to Plymouth which is about 10 miles away on a bus. It's a long journey which I wouldn't be able to do without my mum. I like my dentist – he's friendly
- That you can get access to emergency care on the same day if you need it

Removal from register

- My dentist's taken me off his practise which I'm not happy about! I received a reminder for a routine check-up but I couldn't go because of work. I asked the dentist to change the appointment which they wouldn't do – they were very inflexible! After that they didn't send me any reminders just a letter to say they had removed me from the practise. I did go to the dentist to ask if they would take me back but they refused so I don't have a dentist now and really need one because I'm having problems with my teeth. I don't think it's very fair!
- Many people have told us (in Saltash) if you're an NHS patient and don't go for your annual dental check-up the practise will take you off. It happens a lot here. Added to this is a problem that because of Data Protection issues some dental practises will not accept the carer or family member ringing to cancel the appointment.
- I've had the same thing happen to me – they removed me from the practise - but I went in and spoke to them. I explained to them and gave them a valid reason after which they accepted me again.



3. Do you agree dental services not being rated in 2015/2016?

The Al Hayat Men's group felt this was fair because CQC needed time to test out their methodologies and would therefore not be accused of bias.

The refugees and asylum seekers also agreed this was fair but felt the decision should be kept under review.

The Derbyshire Gypsy Liaison group felt that CQC should give the dental practises a rating but not publish it.

In the other groups, some felt this was NOT fair and CQC should be rating dental services in 2015/16.

- CQC should see what is happening on the ground and should be rating them!
- I agree – they should be monitoring how they communicate with people with Learning Disabilities – whether they use accessible formats and documents or not and rate them!

Others felt this WAS fair because CQC needed time to test out their methodologies or they didn't feel ratings were important.

- If ratings are based on opinions then need to be careful as a dentist might be good but if people hate going to the dentist they are going to give them a bad score.
- I'm not really fussed about ratings. You don't really have a choice where you go.
- I wouldn't be able to travel if a better dentist was a long way away.
- You have a choice whether you want to go to the dentist or not. It's not the same as going to the hospital which could be a matter of life and death – so the risk is less. For this reason I don't think ratings matter that much.
- I don't need to see 'star ratings' so long as I can get access to the dentist when I need it.
- I wouldn't look at the ratings; you soon find out if it's a good or bad dentist and decide to stay or leave.