The future of dental service regulation
Foreword

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

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

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

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


Dr Janet Williamson
On behalf of the Regulation of the Dental Services Programme Board
Introduction
Changes to the health and social care landscape – and the regulatory landscape for dentists - have provided an ideal opportunity to review and improve the overall approach to dental regulation in England.

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

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

Its work is supported and underpinned by;
- NHS Business Services Authority (NHSBSA)
- Healthwatch England

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

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

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

We held two stakeholder events in March and June 2015. The feedback we received told us that the system for the regulation and commissioning oversight of the provision of dental services isn’t working as well as it could. There is duplication between the different regulators. It is difficult for patients to know where to find information about services and to know who to talk to when care does not meet required standards. Dental stakeholders feel that the stress that the regulatory system can place on dentists is disproportionate to the level of risk to patient care.
This report marks the first stage in a process of reviewing the future of dental service regulation. It is also part of the process in establishing greater public and professional confidence and this report will help to continue that discussion.

**Key findings**

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

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

- There is no clear definition of roles and responsibilities, with limited understanding between organisations of who does what, when and how. Consequently there is duplication and inefficiency within the system.
- There is no clear model. The changes in the commissioning context, combined with the introduction of system regulation, have led to a confusing system with incoherence as to the relationship between performance management and regulation.
- There is limited data sharing to manage risk proactively and learn from what is improving. There is no common data set on quality and safety to enable regulators to establish overall safety of dental services across England. The current model of regulation is also not underpinned by a common data set of information sources we all use and how we currently share them. Hence there is no common understanding of risk – what flags a risk, where does it go, and who is the best organisation to deal with the issue. This is compounded by the difference in data available for NHS dentistry in comparison to private practitioners.
- When complaints arise, or issues such as infection control surface there is potential for the same individual to be scrutinised by three organisations (CQC, GDC, NHS England) for the same issue, all of whom have the power to impose significant sanctions. There are other bodies who may also inspect dental practices – for example Health Education England and Public Health England.
- There is limited support for quality improvement across the regulatory system. There is a lack of clarity as to who leads on supporting ‘failing’ practices/
vulnerable practitioners and for improving quality more widely across the dental sector.
- There is limited communication with dentists and patients. We do not communicate with our key stakeholders in an effective and sustained way.

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

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

We have identified areas where the system doesn’t work and will work with stakeholders to change and identify better ways of doing this. We recognise that this will require more input from members than the board alone. We committed to publishing our thinking and our findings after a year and we welcome your continued engagement as we continue our work with your help.

In order to address these issues, we have identified areas where progress should be made over the next year. Stakeholders told us that any future design/model should be based on a number of clear principles. This must be the foundation on which we make any change. We are committed to change. We will follow these principles that we have co-produced with our stakeholders and use them to underpin our future work:

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

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

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

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

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

Until now, there has not been a review of the system to see if it’s working effectively; to recognise the changes within the system and to view their impact at strategic and operational level.

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

The GDC is the professional regulator for dentists and was established in 1956 to set and maintain standards of practice and professional conduct in UK dentistry.

NHS England is responsible for commissioning NHS dental services and for carrying out contractual compliance and performance monitoring. A national performers list managed by NHS England was introduced on 1 April 2013 after Primary Care Trusts (PCTs) were disbanded. CQC is the system regulator for dental practices. It monitors and inspects dental practices and checks whether dentists are providing services which are safe, effective, responsive, caring and well-led in accordance with regulations.

**Regulatory framework**

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

1. General Dental Council – Dentists Act 1984 (as amended)
2. Care Quality Commission – Health and Social Care Act 2008
In addition, legislation governing all of health and social care – the Safeguarding Vulnerable Groups Act 2006 – creates the Disclosure and Barring Service which has powers to prevent dental professionals from working within the health service.

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

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

The Board also included two other partner organisations with an interest in improving the current system.

NHSBSA, formerly known as the Dental Practice Board, was established in 1948 to assess claims from dentists for payment for NHS services and has since 1990 taken a role in monitoring and investigating inappropriate treatment activity by NHS dental contractors. Since 2011 when CQC’s role came into being, BSA changed the way it monitored dentists from a routine practice inspection approach to a pure risk based approach using Clinical Advisors.

The Healthwatch network collects the experiences of the public and their use of health and social care services, either directly or through a local network of community groups.

Opportunities for change

Our work has identified the following six areas for change and action

Roles and responsibilities of regulators

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

People working in the GDC, CQC, NHS local teams, and the NHS BSA, find it difficult to understand the regulatory processes of partner organisations. Issues are potentially not being resolved at local level where possible (for example, complaints) or dealt with collectively with a proportionate response.
From the perspective of the dentist, there is a lack of clarity and often misunderstanding about which organisation does what. One stakeholder, referring to the level of burden and scrutiny by regulators and commissioners stated, ‘you say its low risk but it doesn’t feel low risk’.

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

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

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

Area for improvement

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

Joined up model for regulation of dental services

Our stakeholders told us they are supportive of regulation but there are too many organisations that carry out inspections (CQC, NHS England, and HEE¹). Overlap causes unnecessary stress and burden on providers.

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

The web survey revealed that there was a lack of clarity about which organisation should deal with a particular issue (e.g. infection control, overcharging, single patient complaints, fraud). There was not a consistent approach about whether each organisation should deal with it on their own, refer it on to another organisation or deal with it jointly with another organisation. This is highly inefficient, meaning that

¹ This isn’t an exhaustive list as other organisations, such as the Health and Safety Executive, have power of entry.
some organisations are potentially getting involved in issues which can and ought to be dealt with by another organisation. This also leads to duplication of effort and can be confusing and frustrating to dental professionals.

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

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

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

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

**Area for improvement**

Define a clear model for the system of dental regulation which ensures strategic /national alignment with local partnership working. This will be done by April 2016. This model should outline a clear framework for risk assessment/methodology. This will be done by April 2017.

**Improved data and intelligence**

Data and intelligence has a vital role to play in any system of regulation. It:

- Identifies the status of individuals or bodies which are subject to regulation (for example, GDC register).
• Enables the regulatory system to identify and investigate breaches and also identify where performance does not meet agreed standards of care and service delivery.

• Gives visibility and transparency to everyone who wants or needs to know the outcomes of the regulatory system (for example, suspension from the GDC register).

• Enables patients, regulators, dental professionals and commissioners to raise concerns or potential risks to appropriate standards of care, or service delivery.

• Enables the system of regulation to continuously improve and evolve.

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

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

Risk is also understood in different ways. Firstly, the areas of risk for the public might be easily separated into structural, clinical and possibly financial in the context of the £22bn efficiency saving required of NHS by 2020. In terms of structural, this mostly relates to environmental factors - such as, is the practice clean, is cross-infection control adequate, is the equipment fit for purpose, maintained and used properly - most of which comes under the area of “safe” in CQC terms.

Clinical risk put simply might be expressed in terms of whether examination and diagnosis are carried out diligently, using current evidence and guidelines; are patients fully involved in treatment decisions, and are those treatment decisions made in the best interests of the patient? In other words it is important that patients are offered care and treatment appropriately, neither neglected, nor over treated.

The NHS oversees in the region of 10,000 primary care dental contracts and collects huge amounts of information that enable trends to be identified at practice level, and sometimes practitioner level. This data can be analysed and can give a good idea about whether diagnosis and treatments are effective. This data also helps ensure value for money by identifying where services might be over claiming and also can indicate whether patients are being charged correctly. It is recognised however that little of this data gives an indication about the actual quality of clinical care. Private routine dental care carries similar risks, but data is more difficult to come by.
In order for the system to focus effectively on higher risk practices and performers, regulatory action needs to be informed by accurate and reliable data and information which can be easily used by case workers, inspectors, clinical advisors and performance leads. Ensuring that each organisation can access relevant information in a format which makes sense to them is something which could be addressed through the development of common datasets and the use of the same identifiers.

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

The gap that we have identified in the parity of information about private practices could be addressed by greater use of accreditation schemes combined with a system for self-reporting to capture corporate data, whilst being mindful of the burden any such system would impose. Drawing more on the theme of self-regulation, there is the potential for some sort of self-report or declaration which meets the needs of both CQC and NHS England, so that it reduces existing separate data requests and comprises a meaningful assessment of quality by each practice.

Notwithstanding this, the benefit of having a central source or repository of information for the use of data and data sharing has been widely recognised. One suggestion is that potentially, all level of concerns/issues/complaints could be handled via a single portal and escalated to other organisations accordingly – for example passed to GDC if a serious fitness to practise issue etc.

The PSA report challenges that “the absence of a consistent risk-assessment methodology is manifest in the current structures of statutory regulation”. So how could we resolve this in practise to ensure we are looking at the right measures / triggers in the first place? The starting point must be to share information in a much more systematic way and to enhance levels of trust between regulatory partners.

**Area for improvement**

- Improve data and information/intelligence sharing, including proactively to plan inspection programme and share learning. **This will be done by April 2016.**
- Establish data sharing agreement with a longer term plan to establish a central source of information for the repository of data and data sharing. **This will be done by October 2017.**
**Complaints**

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

Patients don’t know who to complain to, information about how to complain is often not made readily available and often patients are reticent about complaining as they fear it will impact on their care. This is of particular concern in the area of dentistry due to limited access to surgeries registering new NHS patients in some areas and continued misunderstanding about the existence of dentist registers.

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

The Dental Complaints Service (DCS) provides impartial advice and mediation for private dental patients and dental professionals who have not been able to resolve a complaint locally about private dental treatment. Although funded by the GDC, they are independent of the Council, the NHS and the Government. Stakeholders were generally very positive about this service. The problem arises when complaints enter the system and organisations are simultaneously dealing with the same issue. For example the CQC do not settle individual complaints about health services but feedback about a practice helps it to decide when, where, and what to inspect.

GDC can only deal with the fitness to practice element but have experienced a substantial increase in the number of complaints they have received over the last few years.

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

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

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

**Area for improvement**

Defined system with recognised roles for complaints handling (this will be done by April 2016), supported by clear signposting processes (this will be done by October 2016).

**Support for quality improvement**

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

Some organisations have stated roles in relation to improvement - CQC encourages improvement, NHS England commissions improvement, and Healthwatch looks at improvement - but these organisations do not have a responsibility to provide or facilitate such improvement support at a practice level or level of the wider system.

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

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

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

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

These suggestions need to be explored, to consider how local systems can best be developed to help stop problems before they happen.
There is a clear gap within the system in terms of framework of support for the profession and a regime for quality improvement. The future solution to this issue needs to go wider than the regulatory bodies.

**Area for improvement**

Define quality improvement in the dental sector and the other stakeholders for improvement by October 2016.

**Improved communication with providers**

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

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

In many cases issues which escalate to the regulators could have been prevented if there was better regarding communicating the expected standards, and tools and resources provided so that dental providers could self-assess their service. This would enable the regulatory system to develop a risk based approach to regulation by concentrating on the small percentage of higher risk practices that require the full focus of regulation.

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

**Area for improvement**

Proactive and regular joined up conversation across the sector (this will happen by July 2016), supported by a clear communication plan (this will happen by July 2016).
Improved communication with the public

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

The regulatory and commissioning framework have to meet the diverse needs of the population we service, the public has a view on the quality of service and the experience of receiving treatment. If they are not sure about that experience or the funding mechanism for treatment, and they may not be clear or comfortable approaching their dentist, then where do they go to get that information? Where local Healthwatch receive concerns about aspects of health and social care (including choice and access to services), they highlight those concerns to Healthwatch England – though an escalation process (Healthwatch England has a “consumer watchdog role”). There are currently 148 local Healthwatch set up in each Local Authority in England.

Healthwatch England has had nine escalations regarding dentistry, on topics including access to NHS dentists, charging, disability access and practice. Concerns can be formally escalated to statutory organisations such as NHS England and CQC. There is scope to do more to align this process of escalating public concerns with any future systems in place for improving the quality of dental services.

Healthwatch identified a need for better information for people to ensure they can make informed decisions about care. In particular, better signposting and wider use of plain English is needed to help ensure patients are accessing care at the right time and that they have the ability to self-care when appropriate.

As part of the approach to developing the new inspection model, CQC commissioned a piece of qualitative research to provide a clear understanding of what the public and service users think ‘good’ and ‘outstanding’ dental services looks like. The key findings were related to communication and trust, personalised care provided by friendly, careful and considerate staff. We know from the Which? dental campaign that patients experience issues around dental costs, price lists not being prominently displayed, and patients not being given information on NHS/private alternatives.

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

**Area for improvement**

Develop a proactive and regular approach to keeping patients informed and involved in the quality of dental services. **This will happen by April 2016.**
The way forward

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

As the GDC research concluded, and as we have found through our work,

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

We have found a compelling case for change and Board members are committed to working together on these areas for improvement over the next 12-18 months. These are essentially short and medium term actions and, whilst we are clear that these areas need addressing, we will continue to ask whether these are the right issues and whether they capture the risks. The big question remains in the longer term, are they radical enough?

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

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

• Should there be fundamental change to professional & system regulation?
• Do we need to change legislation as there is over regulation?
• Is regulation the most effective use of resources?
• Should there be a single set of standards?
• Self-regulation in a system that is potentially low risk?

The current picture of dental regulation is perhaps a reflection of the proliferation (of regulation) problem that the PSA describes in their report although there are of course some obvious differences. One of the most significant is that dentistry doesn’t often feature within the wider political debate about the healthcare system and the nuances aren’t necessarily captured within differences between professional and system regulation.
Most importantly this is an opportunity for reflecting and learning across the system.

We suggest that the following characteristics should be embedded within any future regulatory system:

- Recognising the diverse needs of the population we serve, assures the safety of all people using services and the quality of treatment they receive
- Promotes and improves quality
- Ensures transparency and enables choice
- Makes sure public funds are used effectively
  - By dentists
  - By the regulators
    - Duplication minimised
    - Resource focussed on the providers/individuals most at risk of providing poor care
- Has a measurable impact on quality
- Is flexible and adaptable to changing context

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

1. Background and Programme context
   The General Dental Council (the professional regulator), Care Quality
   Commission (the systems regulator), NHS England (the commissioner of NHS
   Dental care services, which also holds a list of suitable performers), NHS
   Business Services Authority (a special health authority of the NHS who pay
dentists and protect the NHS from fraud), Healthwatch (national consumer
   champion in health and care) and the Department of Health have a mutual
   interest in ensuring that patients receive high-quality, safe dental services from
   professionals and organisations that are competent and meet national standards,
   and that services improve.

2. Purpose
   To review the approach to dental regulation across England and assess
   effectiveness of current arrangements to determine an effective model for
   regulation for the future. The scope will predominantly be primary care, but will be
   mindful about implications for secondary care and responsibilities across the
   system including for care pathways. Specific outcomes:
   
   2.1 Identify roles and responsibilities
   2.2 Determine the effectiveness of current approaches
   2.3 Assess consumer and stakeholder views of dental services across England
   2.4 Develop proposals for alternative model(s) for performance management,
       inspection and regulation
   2.5 Option appraisals and business case
   2.6 Effective information sharing
   2.7 Communication plan

3. Membership
   Janet Williamson - Deputy Chief Inspector Primary Medical Services Central
   Region (Chair), CQC

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

   David Geddes – Head of Primary Care Commissioning, NHS England

   David Rowland – Head of Corporate Policy, GDC (Evlynne Gilvarry from June
   2015)

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

   Susan Robinson – Head of Development, Healthwatch England

   Claire Robbie – Regulatory Policy Manager, CQC

   Amanda Hutchinson – Head of Primary Care & Community Services Policy, CQC
4. Quorum and Decision Making
4.1 The quorum for transaction of business shall be representation from four out of the six organisations.

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

5. Frequency of Meetings
12 month duration for meetings occurring:

- September, November 2014

6. Governance arrangements
Members will report to their respective Boards in the following ways:

- **NHS England**
  Reports to the Primary Care Oversight Group (PCOG). PCOG reports to the Directly Commissioned Services Committee (DCSC) and DCSC are a sub-committee of the NHS England Board.

- **GDC**
  Reports to the GDC Council which convenes every six weeks.

- **NHS BSA**
  Reports to the NHS BSA Board which meets eight times a year.

- **DH**
  Reports to Dan Poulter and other Ministers.

- **CQC**
  Reports to the PMS Monthly Performance Group meeting and the PMS Senior Leadership Team which convenes weekly. Additionally Professor Steve Field will provide regular updates to the Executive Team.

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

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

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

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

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

From April 2015 we will regulate primary care dental services.

If we find that a service isn’t meeting our standards, we take action to make sure it improves. We have a range of powers that we can use.

Healthwatch England
Healthwatch England is the national consumer champion in health and care. We have significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.
Appendix C – References

Works Cited


Healthwatch reports

‘Local Healthwatch Investigates’

7 point action plan

‘Suffering in Silence’

Local Healthwatch reports:

- Barnet: Dentistry in Barnet
- Barking & Dagenham: Children & Young People
- Bedford: Visiting a Dentist can Save Your Life
- Blackburn and Darwen: Giving Healthwatch Nice Teeth (developing toolkit), Report in partnership with Blackburn College investigating the experience of young residents accessing GP, Dental, and Sexual Health services
- Bolton: Accessing NHS Dentistry in Bolton, Oral Health Care in Residential Care Homes
- Bristol: NHS Dentists not offering NHS Appointments
- Buckinghamshire: Healthwatch Bucks NHS Dentist Report
- Cambridgeshire: flow chart “How to make a complaint about Health Services – Primary Care/NHS England”
- Dorset: Primary Care Dental Services in Dorset
- Ealing : Tell HW Ealing about NHS Dental Services Report – April 2014
- Hampshire: The Whole Tooth – study into General Dentistry Services in Hampshire
- Isle of Wight: Dental Services Report and dental seminar with NHS England Q&A
- Kent: Considering project
- Kirklees: Tell us about NHS dentists and oral health. Are all dentists in Kirklees registered with the General Dental Council (CDC)? How do I find an NHS dentist in Kirklees?
- Leeds: Tell us about NHS dentists and oral health
• Leicester: NHS Dentistry in Leicester City
• Liverpool: Access to NHS Dental Services
• Newcastle: Young People’s Dental Health Project in Newcastle
• North Somerset: ‘NHS Dentists’ not offering NHS appointments
• Northamptonshire: NHS Dentist Complaints
• Rotherham: Access to Dental Practices
• West Berkshire: Dental experiences – Live report updates