Aim of today

- Share the progress and achievements of the RDSPB
- Shape implementation with the dental sector
- Ask for the sector’s engagement
Working together today
<table>
<thead>
<tr>
<th>Agenda item</th>
<th>Lead</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Arrival and registration</strong></td>
<td>Janet Williamson, Chair of the RDSPB</td>
<td>9:30am</td>
</tr>
<tr>
<td>Welcome and introduction – “What has the RDSPB achieved so far?”</td>
<td>John Milne, CQC</td>
<td>10am</td>
</tr>
<tr>
<td>RDSPB: Improving quality</td>
<td>Mick Armstrong, British Dental Association</td>
<td>10:20am</td>
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<tr>
<td>Supporting implementation: Thoughts of the BDA and the FGDP</td>
<td>Paul Batchelor, Faculty of General Dental Practice</td>
<td>10:40am</td>
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<tr>
<td>Supporting implementation (table discussion)</td>
<td>Janet Clarke, NHS England</td>
<td>11:20am</td>
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<tr>
<td><strong>Lunch</strong></td>
<td></td>
<td>12:05am</td>
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<tr>
<td>Closer working and reducing the burden:</td>
<td>Jane Brown, Healthwatch</td>
<td>12:45pm</td>
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<tr>
<td>• Healthwatch and CQC: a case study</td>
<td>Tracy-Jayne Norton, CQC</td>
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<tr>
<td>• The operational protocol in action: perspectives from the GDC,</td>
<td>John Cullinane, GDC</td>
<td></td>
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<tr>
<td>NHS England and CQC</td>
<td>Carol Reece, NHS England</td>
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<tr>
<td>What more do we need to do to engage? (table discussion)</td>
<td>Julie Richards, CQC</td>
<td></td>
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<tr>
<td>Panel discussion and Q&amp;A</td>
<td>Board members</td>
<td>14:15pm</td>
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<tr>
<td>Wrap up and close</td>
<td>Janet Williamson</td>
<td>14:50pm</td>
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</table>
Purpose of the Board

- Review the approach to dental regulation across England
- Assess effectiveness and identify issues with current arrangements
- Agree an effective way forward for improving the model for regulation for the future
### A three year journey

<table>
<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
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</thead>
<tbody>
<tr>
<td>Summer 2014</td>
<td>RDSPB established, begins to develop aims and objectives</td>
</tr>
<tr>
<td>February 2015 – June 2015</td>
<td>Two stakeholder engagement events</td>
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<tr>
<td>December 2015</td>
<td>Proposals published in <em>The future of dental service regulation</em></td>
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<tr>
<td>From April 2016</td>
<td>Begin implementing agreed RDSPB proposals</td>
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<tr>
<td>June 2017</td>
<td>Working together, delivering change published looking back at the work of the Board</td>
</tr>
<tr>
<td>September 2017</td>
<td>Third stakeholder event, canvassing the sector on implementation</td>
</tr>
</tbody>
</table>
Workstreams

Data sharing

People's involvement

Complaints handling

Working together

Supporting improvement
What has the RDSPB achieved so far?

- Significant progress on the opportunities for change identified in December 2015 report:
  - Quality improvement framework
  - Joint working protocol
  - Complaints statement
- Risk and oversight group
What has the RDSPB achieved so far?

- You should expect to see increased collaboration and partnership between CQC, GDC, NHS England with the aim of a single shared view of quality.
- Working together, delivering change.
- Delivered strategically on our commitment, now moving into a focus on continual engagement and implementation.
Key reflections from RDSPB members

“The RDSPB model has been replicated with the introduction of a GP regulation board and in Adult Social Care Quality Matters. The model can be seen as a pioneer”

“Built trust across organisations”

“The Board set the tone for collective strategic permissions – act, respond and share”

“Collective listening, observing and understanding”

“It has delivered what it set out to do”
RDSPB: Improving quality

John Milne, National Professional Dental Advisor, Care Quality Commission

#RDSPB2017
Sir David Behan – 5 pillars of improvement

• What **Commissioners** do and how they do it.
• What **Providers** do, and how they do it, from the board to the front line.
• What registered **professionals** and clinicians do - all undertake a personal commitment to deliver safe high quality care when they register.
• What **regulators** do and how they do it. This includes quality regulators, system regulators, but also professional regulators.
• The **voice of people** who use services
Quality improvement framework

Stage 1: Routine self regulating
   - No concerns

Stage 2: Peer support
   - Minor concerns

Stage 3: Formal supervision
   - Moderate concerns

Stage 4: Limits to practice
   - Severe concerns

Improvement following external intervention programme

Possible concerns

Urgent concerns

Emerging concerns

Source: RDSPB, A model for quality improvement across the dental sector, 2017
Professionalism is the key to quality

- Doing the right thing when no one is looking!
- Everyone in a practice is responsible for quality care that is safe.
- Self regulation per-se might be historical, but professional responsibility is still present today
Quality improvement framework

- Peer Review Groups
  - Reduce isolation
  - Safe environment for learning and reflection
  - Works well when structured and written up

- Appraisal and planned CPD
  - Personal development
  - Individual reflection
Quality improvement framework

- Clinical Audit
  - Audit leaders
  - Topics can be individual interest
  - Or national/regional or local

Stage 1: Routine self regulating
No concerns
Quality improvement framework

- PASS schemes
  - LDC led
  - Validated and recognised
  - Safeguards
  - Trained mentors
  - Can build on audit, peer review and appraisal
Quality improvement framework

- Revive Peer Review
  - Works well when structured
  - Combats isolation
- Resuscitate Clinical Audit
  - Training
  - Topics that interest the practice
- Mentoring
  - Training
- PASS schemes
  - Recognised, trusted, effective
Challenges

- Getting buy in
- Time, commitment and funding
- NHS targets
- Skilled leaders and facilitators
- Competent mentors
- Identifying and encouraging those who don’t engage
- Fear of involvement
Key players (apologies for any omissions)

- BDA branches
- BDA
- HEE
- LPN
- FGDP + FDS
- LDC
- DCP
- NHSE
- Corporate groups
- Plan providers
- Indemnity Providers
A call to action – the challenge is ours

- Challenge for the regulators
- Challenge for professional bodies
- Challenge for Individual professionals.
Supporting implementation: Thoughts of the BDA and the FGDP

Mick Armstrong, Chair of the British Dental Association
Paul Batchelor, Faculty of General Dental Practice

#RDSPB2017
Quality Improvement Framework - supporting implementation

Mick Armstrong
Chair
British Dental Association
Overview

- A few words about the RDSPB and the current work
- Audit and peer review
- What we might be able to do
- Problems and issues for discussion
Work of the RDSPB

• Stakeholder workshop

• Complaints statement

• Quality improvement model
Quality improvement model - RDSPB

Stage 1: Routine self regulating
No concerns

Stage 2: Peer support
Minor concerns

Stage 3: Formal supervision
Moderate concerns

Stage 4: Limits to practice
Severe concerns

Improvement following external intervention programme

Possible concerns

Emerging concerns

Quality line

Source: RDSPB, A model for quality improvement across the dental sector, 2017
Some quotes from the report

• ‘upstream shift in resource and energy’

• ‘empowering the profession’

• ‘a single shared view of quality’ by GDC, CQC and NHSE

• Call to action for the profession
Audit and peer review

• Central clinical audit and peer review scheme in early 2000s
• Stopped in 2006 in England
• Wales, Northern Ireland and Scotland continue programmes and funding
• England – mainly voluntary basis
• BDA Good Practice, DFT, BDA Branches have a role
• Practitioners generally positive about it
• Focus on Peer Review – NOT performance management
Peer review (1)

• Practitioners get together to discuss an agreed topic

• Needs a leader to put group together and make arrangements

• Practitioners meet, discuss, implement new ideas and report back.
Peer review (2)

- Many undertake peer review because they have an existing group.
- What about those who don’t?
- What about the quality assurance of existing groups?
- What about sharing the knowledge?
- What about DCP groups?
BDA ideas (1)

• The BDA, in conjunction with others, is able to develop a scheme:
  
  • Arrange it (through existing and new structures, LDCs, professional bodies etc)
  • Quality-assure it with the FGDP
  • Provide necessary training for those involved
  • CPD
BDA ideas (2)

- BUT
- We can’t do it alone
- We can’t finance it.
BDA ideas (3)

• Not performance management, but:
• It needs to be considered what happens if serious standards issues come to light
• If participation is not mandatory, what about those who don’t participate?
PASS schemes

- Role
- Where and how many
- Funding
- BDA Branches
- LDCs
Discussion

• A general overview has been given
• There are many things we are aware of we haven’t mentioned
• Main problems to move forward:
  • Appropriate finance and support
  • Researching what exists and who participates
  • If profession-wide, involvement of DCPs, HEE, (GDC?) and others
Thank you
DEVELOPING CLINICAL AUDIT AND PEER REVIEW AS A MECHANISM TO IMPROVE THE QUALITIES OF CARE

Paul Batchelor
6th September 2017 | HFMA, LONDON
• understanding of why we are here
• current relationships
• arrangements of care provision
  • NHS, non-NHS balance
  • workforce
• care structures
HIGH PERFORMING HEALTH CARE SYSTEM

• Consistent leadership that embraces common goals and aligns activities throughout the organisation.

• Quality and system improvement as a core strategy.

• Organisational capacities and skills to support performance improvement.

• Robust primary care teams at the centre of the delivery system.

• Engaging patients in their care and in the design of care.

• Promoting professional cultures that support teamwork, continuous improvement and patient engagement.

• More effective integration of care that promotes seamless care transitions.

• Information as a platform for guiding improvement.

• Effective learning strategies and methods to test improvements and scale up.

• Providing an enabling environment buffering short-term factors that undermine success.
“The key to patient safety lies in effective face-to-face communication between patients and healthcare staff or between the different staff involved in the care of an individual patient.”

Daker-White et al., 2015
“(Public) trust in the health care system is influenced not only by the health care system itself, individuals’ experiences of it and its media image but also by discourse in the public sphere about individuals’ experiences and the system as a whole.”

Gille et al., 2017
CHARACTERISTICS OF TRUST SPECIFIC TO THE HEALTH CARE CONTEXT

- Stronger affective component (vulnerability)
- Altruism – working in best interests of patient (honesty, confidentiality, caring and showing respect)
- Competence (social and technical)
“(C)urrent models that provide one-off training in incident disclosure or communication are not sufficient to drive the cultural change required. A model of training and supervision that integrates these nontechnical knowledge and skills in an ongoing process throughout a clinician's career is essential.”

Harrison et al., 2016
High Trust

Professional model
(accountability implicit)

Stakeholder model
(accountability explicit)

Low Trust

Bureaucratic model

Market model
(choice)

New Public Management model

Low Control

High Control

Low State

High State
IMPLICATIONS

- approached required that adopts the ‘whole’ system recognising that the NHS is one component
- embedded within an environment of ‘life-long’ learning
- profession led with clarity in standards
- support mechanisms
- trust
Supporting implementation

Janet Clarke, Deputy Chief Dental Officer, NHS England

#RDSPB2017
Discussion questions

• How can your organisation support implementation?

• Are there any quality improvement mechanisms missing? How can your organisation help deliver these?

• How can your organisation encourage participation by all?
Lunch

Please return to your seats by 12:40pm please
Closer working and reducing the burden
Background

- Approached by Public Health (Dental) locally to support an oral health needs assessment
- Following up the project recommendations
- Developing partnerships
- Preparing the materials for the Healthwatch ‘Enter and View’ visits
CQC – preparing to inspect

- Available information held by CQC
- Information requests to NHS England and Healthwatch
- Standardised pre-inspection request (PIR)
- What do all of the above tell us? How do we get more information, preferably before scheduling?
- Inspection Manager liaison with Healthwatch and inspection team support for the enter and view tool.
Visits to Dental Practices

• Pilot in Welwyn and Hatfield District key findings
  o Accessibility
    • Physical
    • Accessible Information Standard
  o Complaints
  o NHS Choices
• Sharing the reports
• Refining the questions for the next District
How CQC uses information from Healthwatch reports

- Issues with physical access to the practice (Regulation 15: Premises and Equipment)
- Lack of emergency equipment such as AED and the relevant risk assessment (Regulation 12: Safe care and treatment)
- Availability of information to complain; general governance issues (Regulation 17: Good governance)

With this information and that already held, the inspector can estimate the level of risk, plan the visit, target areas of concern to assess the risks as well as use the positive findings as assurance.
The benefits of working together

For CQC

• A template for other working relationships with local Healthwatch
• Identification of risks and possible mitigation of risk if providers act upon Healthwatch recommendations
• Helps to inform inspection schedule (risk based)

For Healthwatch

• Opportunity to share results of our work more formally
• Provides a forum for sharing soft intelligence
• Enables wider shared working between the two organisations as well as LDCs and Public Health
The operational protocol in action: perspectives from the GDC, NHS England and CQC

John Cullinane, GDC
Carol Reece, NHS England
Julie Richards, CQC

#RDSPB2017
Operational protocol

- The joint Operational Protocol has been developed so that we can work more effectively together and reduce duplication.

- NHSE and CQC local liaison meetings are working well

- NHSE colleagues have collaborated on CQC inspections

- Regular meetings between GDC Casework Manager and CQC Head of Dental Inspections to discuss cases

- Improved relationship between GDC casework staff and CQC inspectors – including attendance at training events
• Working with CDOs and NHE organisations in all UK nations to achieve a more proportionate system of dental regulation

• Exploring whether effective clinical governance can play a more central role in learning and quality improvement.

• Risk and oversight group
NHS Concerns

Launched in June 2016

Calibration group now in place to:
• promote learning and improvement in the NHS Concerns Handling process
• use learning from the pilot to extend collaboration more widely, this may include (but not necessarily limited to) health services in Scotland, Wales and Northern Ireland, practices providing private treatment and to corporates;
• foster mutual understanding of the types of concerns that should be handled by which organisation

GDC now employing clinical advisers – senior adviser will sit on calibration group to give clinical perspective.
### NHS Concerns

<table>
<thead>
<tr>
<th>Concern</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where the registrant has failed to adequately explain the charges for treatment</td>
<td>4.9%</td>
</tr>
<tr>
<td>Where the primary concern is poor communication</td>
<td>21.9%</td>
</tr>
<tr>
<td>Where there is evidence of inadequate complaints handling</td>
<td>9.9%</td>
</tr>
<tr>
<td>Which involve low level behaviour or attitudinal concerns, and have no element of discrimination, violence, and do not concern vulnerable adults or vulnerable children</td>
<td>16.1%</td>
</tr>
</tbody>
</table>
### NHS Concerns

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where there is evidence of minor issues in relation to record keeping</td>
<td>1.0%</td>
</tr>
<tr>
<td>Where there are issues accessing NHS dental care due to contractual capacity</td>
<td>10.3%</td>
</tr>
<tr>
<td>Which involves a single clinical incident where there is no evidence of repetition or an ongoing pattern of behaviour and the case is not so serious that it raises fitness to practice issues</td>
<td>24.5%</td>
</tr>
<tr>
<td>Which involves multiple low level clinical concerns over several appointments or which may involve a number of individual complaints on similar issues which do not raise fitness to practice concerns</td>
<td>11.2%</td>
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</tbody>
</table>
NHS England South East Meets with CQC via a telephone call once a month and the purpose of the call is to share intelligence regarding the practices providing services to NHS patients.

- Where are CQC planning to inspect in this quarter?
- Any non-urgent issues arising at inspections
- Sharing information of concern highlighted to the CQC or NHS England
- Where are the area team visiting?
- Any issues that NHS England are aware of with practices?
CQC and NHS England - response

• Concern raised by NHS England with CQC
• CQC carried out a management review meeting and a decision was made to issue a notice of proposal to cancel the registration
• The provider responded by voluntarily closing to carry out the required work
• NHS England visited and supported the practice and helped them to put together a relevant action plan.
• follow up inspection would be carried out jointly by the CQC and NHS England
CQC and NHS England - impact

- At the follow up inspection the practice was found to have improved substantially and the report reflected the improvements
- NHS England continue to monitor the practice and provide updates to the CQC
- The approach taken jointly by the CQC and NHS England required robust communication channels and an understanding of what each organisation was asking the practice to do to be compliant and safe for their patients
- Working together the CQC and NHS England ensured that the practice became compliant, understood their responsibilities and maintained the improvements whilst being guided and well supported
Perspectives from NHS England

- GDC and NHS England liaison meetings for case discussions
- Joint complaints acknowledgment correspondence between GDC and NHS England
- Liaison meetings for case discussion taking place between NHS England and CQC inspectors
- Enhanced relationship between commissioners and CQC inspectors
- Regularly held workshops and combined dental leads/GDC and CQC meetings
The operational protocol: table feedback

• We would like your input and views as to whether you think this will help to make a difference.

• This is the second iteration as we look to build on stronger relationships between organisations

• Copies of the protocol on each table – please complete the front sheets and return to the table facilitator at the end of the day.

• Next steps - we will publish the protocol on the RDSPB web page after collating and considering your comments.
What more do we need to do to engage?

Carol Reece, Head of Dental and Optical Services Commissioning, NHS England
Table discussion

- How can the profession work in partnership with the regulatory and commissioning system?

- How can we improve the opportunities to get a common understanding of the challenges facing the local health community?

- Are Local Dental Committees the correct route to engage, or are there other routes?
Panel discussion and Q&A

Board members

#RDSPB2017
Wrap up and close
Thank you