Interview with the Care Quality Commission
Neel Kothari speaks to the CQC’s Linda Hutchinson

Now that the impact of the CQC is finally upon us, the clarity of the CQC’s role, remit and function is still hazy, with many within the profession still questioning its necessity. Whilst the coalition government’s pledge to abolish excessive regulation has made a tortoise-like start, it seems that, whether we like it or not, the next level of regulation involving compliance with the CQC must be adhered too.

To help separate myth from reality, I raised many of the profession’s concerns with Linda Hutchinson, director of registration at the CQC to see whether the fears of the profession have merit or are merely a result of scaremongering.

Neel Kothari (NK): There has been a lot of speculation around the remit of the CQC; can you help sort out fact from fiction?

Lind Hutchinson (LH): The Care Quality Commission (CQC) is the independent regulator of all health and adult social care in England. Our aim is to ensure the quality and safety of care, wherever it is provided. We also seek to protect the interests of people whose rights are restricted under the Mental Health Act. We promote the rights and interests of people who use services and have a wide range of enforcement powers to take action on their behalf if services are unacceptable.

We are introducing a new registration system that brings the NHS, independent healthcare and adult social care under a single set of essential standards of quality and safety for the first time. Registration is a legal license to operate. We register health and adult social care services if they meet the essential standards and we continuously monitor them to ensure they continue to do so as part of a dynamic system of regulation which places the views and experiences of people who use services at its centre.

NK: How justifiable are the CQC fees, given that the profession already pay for GDC regulation - and what sort of future increases do you envisage?

LH: Registration with CQC is the law and the fees are calculated on the estimated cost of regulation. There were based on a similar provider type, independent GPs, although the fees could change over time once we have a clearer idea of how much authority is required for this sector in terms of compliance monitoring.

NK: How is the CQC actually going to manage the practice inspection process? Are you going to target certain practices before others?

LH: We will target our initial compliance reviews where we have the greatest concerns. We have recently carried out pilot projects on how we will monitor dental providers’ compliance with the essential standards of quality and safety.

NK: What level of experience with dentistry will the practice inspectors have?

LH: Our inspectors are experts in regulation and cover a diverse range of services which are already regulated by the CQC. An inspector may have a portfolio of services they regulate including care homes, children’s health services, substance misuse services, prisons and independent doctors. We are confident that our inspectors and assessors can confidently audit primary dentistry care to this range.

Inspectors and assessors are receiving bespoke training on the regulation of dental providers currently. We also have a national advisor on dentistry and a provider reference group, which we consult regularly on registration issues. As with other services, we will bring in specific expertise if required.

NK: What sort of burden do you think this will impose on practice staff such as receptionists and nurses?

LH: There are no specific requirements for practice staff other than to contribute to essential standards of quality and safety for the provider.

NK: How consistent has information from the CQC helpline been and has this thrown up any problems with the dental profession?

LH: We are confident about the advice provided by our national contact centre. Our advisors receive five weeks’ training before they start handling calls and if advisors are unsure about how to respond to a query, they seek further advice from a range of sources.

NK: If it is shown that over-regulation directly or indirectly has a detrimental effect on patient care, how would you as a regulator feel about it and would you recommend to the DH that your remit is scaled back?

LH: Regulation is in the best interests of patients and providers. In fact, registration will be an enhancement to providers who meet the essential standards. Regulation is based around providers meeting the essential standards, which are based on outcomes, the experiences people have. This system puts patients at the centre of care.

NK: Why has CQC only focused on practice policies and protocols and not actual clinical care at the point of delivery?

LH: The system of registration focuses on outcomes, which are based on the experiences patients have, rather than inputs, and we make no apologies for this.

We only normally inspect policies and protocols if we are looking for answers about questions that we have identified about outcomes for people. Our system of checks and inspection is driven by monitoring outcomes, through quality and risk profiles. We define outcomes broadly so as to include both clinical outcomes and people’s experiences.

NK: How will CQC monitor compliance after 1 April?

LH: All providers will have a planned review at least once every two years and can have a responsive review at any time. Responsive reviews will happen if we have specific concerns about a provider. If you are registered with conditions on your registration, you will be subject to review more than if you have no conditions. This is a risk-based regulatory system.

So there we have it guys, did it help? Is there anything else anyone wants answered? If so please email me at neelkothari@hotmail.com and I will do my best to raise it with the CQC.

About the author
Neel Kothari qualified as a dentist from Briston University Dental School in 2005, and currently works in Camberwell as an associate within the NHS. He has completed a year-long postgraduate certificate in implantology at UCL’s Eastman Dental Institute, and regularly attends postgraduate courses to keep up-to-date with current best practice.