Following the rules

Chris Hindle looks at how measures flowing from the Health and Social Care Act 2008 will affect dentists and their business plans

As a solicitor dealing predominantly with the business affairs of dentists, I am acutely aware of the concerns in the dental profession, which flow from the Health and Social Care Act 2008 and the measures being introduced. The Act contains 175 sections, 15 schedules and provides for the introduction of further regulations, codes of practice and guidance to be published by the Secretary of State if required.

Subsequently, there have now been 28 published regulations setting out certain essential and politically correct standards of quality and safety that dentists are required to acknowledge. The outcomes are apparently meant to be helpful by providing dentists with prompts to help them comply. On top of all this, there is written guidance to help interpret the regulations.

The main objective of the Act is a sweeping one: to protect and promote the health, safety and welfare of people who use the health and social care services (s.3 (1)).

The Care Quality Commission

In order to provide services all dental practices, NHS and private, have to be registered with the newly created, integrated regulatory UK public body, The Care Quality Commission (CQC), by 1 April next year. Thereafter, they can look forward to compliance monitoring.

Eager dentists can enrol from 1 October, although there is some suggestion that the CQC still doesn’t know what it wants from dentists to facilitate this. At least doctors are more fortunate as they have a year longer to register. There are harsh potential penalties for not registering, with fines of up to £50,000, 12 months’ imprisonment, or both.

Under Section 86 of the Act, dentists could be issued with fixed penalty notices for non-compliance and there will be powers for the CQC to take enforcement action if practices are not up to scratch; practices may even have to have their own registered managers.

Practitioners can seemingly take no comfort at all, considering one of the stated aims of the CQC, which is a commitment to reducing bureaucracy and unnecessary regulatory burden - to avoid duplication and promote “joined up care”. They seem to be doing the reverse of the statement: they think that by saying what they are not going to do will fool us, and that nobody will notice when they go on and do exactly the opposite.

Local decontamination units

One of the main issues for primary care dentists is, of course, the requirement to have on site their very own Local Decontamination Unit (LDU) - a sterile unit for the decontamination of reusable dental equipment. The 95-page best practice advice booklet, A Health Technical Memorandum, gives full details of associated objectives behind LDUs; the sterile equipment is inevitably moved into the non-sterile environment of the surgery where there is no effective control over what happens to it. Nevertheless, one of the preferred objectives behind LDUs is to try and counter the risk of the human variant of Creutzfeldt Jacob disease being caught from re-usable, steel dental instruments; add to this further concerns about passing on MRSA and hepatitis B - one can hardly deny a highlighted need for patient safety.

Negative impact?

Concerns that dental practices might have to close, due to the cost of creating LDUs or because of a lack of available installation space, appear unfounded.

Incidentally, this is only part of a suite of nine such useful memos, comprising assorted health subjects. The LDU issue is an important one and seems in part to have originated in 2001 with The Glennie Report, which reviewed the sterile service provision across the NHS in Scotland.

There is of course a question mark as to the effectiveness of LDUs; the sterile equipment is inevitably moved into the non-sterile environment of the surgery where there is no effective control over what happens to it. Nevertheless, one of the preferred objectives behind LDUs is to try and counter the risk of the human variant of Creutzfeldt Jacob disease being caught from re-usable, steel dental instruments; add to this further concerns about passing on MRSA and hepatitis B - one can hardly deny a highlighted need for patient safety.

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Undoubtedly, the work of the CQC has created a new range of work for some manufacturers and also those eager to advise dentists on their new responsibilities - best-practice advisers and CPD providers, to name a few.

Published information on Wikipedia about the CQC does not help inspire confidence. A recent staff survey identified that 86 per cent of them have no confidence in the executive team and 82 per cent thought it unsafe to speak up and challenge what they were doing. The high-profile CQC Chairman, the Baroness Young of Old Scone, resigned her post at the beginning of the year in an apparent breakdown with Labour Ministers; raising serious questions about Lady Young's confidence in the Government and the Health Service.

The future

It does seem that despite the change in government and the promise of less bureaucratic interference and state control in all our lives, this is an area where the influence of the 'Nanny State' continues to dominate. Looking to the future, one also wonders how far compliance with the new quality rules, aside from pleasing patients, will be used as a pre-requisite to qualify dentists to undertake NHS work and indeed also qualify them for membership of organisations such as Denplan and Practice Plan. Compliance will certainly help all those bodies, private and public, in determining who they favour.

About the author

Chris Hindle qualified as a solicitor in 1991 and is a partner with Leeds-based specialist dental lawyers, Cohen Kramer. He has extensive experience advising clients who are buying and selling property and of landlord and tenant matters, including drafting leases and landlord consents. He acts for clients in the acquisition of development sites and retail/industrial estates. To contact him, email Chris.hindle@cohenkramer.co.uk.