Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspection) (Amendment) Regulations (Northern Ireland) 2010

2 December 2010

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspection) (Amendment) Regulations (Northern Ireland) 2010

2 December 2010

Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mr Pól Callaghan
Mr Alex Easton
Mr Tommy Gallagher
Mr Sam Gardiner
Mr Paul Girvan
Mr John McCallister
Ms Sue Ramsey

Witnesses:

Ms Claudette Christie	)	
Dr Peter Crooks	)	British Dental Association Northern Ireland
Mr Seamus Killough	)	
Mr Billy Baird	)	
Dr Jim Livingstone	)	Department of Health, Social Services and Public Safety
Mr Donncha O'Carolan	)	

The Chairperson (Mr Wells):

We now have an evidence session with representatives from the British Dental Association (BDA) Northern Ireland. I welcome Claudette Christie, who was with the Committee on Tuesday at the speed-dating event and is the director of BDA Northern Ireland — you are very welcome again; Peter Crooks, who is the chair of the Northern Ireland dental practice committee; and Seamus Killough, who is the chair of the BDA Northern Ireland council. You have the usual 10 minutes in which to make your presentation. We already have some idea of your concerns and are interested to hear further material on the issue.

Ms Claudette Christie (British Dental Association Northern Ireland):

Thank you for inviting the BDA to give evidence on the Regulation and Improvement Authority (Independent Health Care) (Fees and Frequency of Inspection) (Amendment) Regulations 2010, which are a matter of great concern to the dental profession and the BDA. I am Claudette, director of the BDA, and Seamus and Peter are with me today. Peter is a general dental practitioner in Ballymena and will talk to you in a few minutes' time.

It is important for the Committee to be aware of the context of dental care provision in Northern Ireland. Dental care is focused on the patient. It can be provided either in a Health Service context or under a private contract, both of which exist alongside each other and complement each other. Each of the 356 dental practices listed by the Health and Social Care Board at 31 March 2010 carries out both Health Service and private dental care. That is the reality of patient choice in dental practice. Things do not exist in isolation; they exist together and complement each other.

Although the legislation sets out that wholly Health Service care is excluded from the legislative process, it is important to be aware that wholly Health Service dental care never exists in isolation. Peter will speak about that. No dental practice can be exempted from the legislation. It is also worth noting that the Health Service is currently a massive provider of dental care in Northern Ireland. It has over 900,000 registered patients, and each practice that provides Health Service care already has a range of governance and inspection regimes in place to ensure that legislation is met and best practice is in place.

I will pass you over to Peter Crooks, the chair of the dental practice committee, who will highlight the concerns of the dental profession about how these regulations will affect dental

practice. We believe that there is duplication and that it will increase the level of bureaucracy. We want members to understand the reality of the small business that is dental practice as it exists in our communities and localities.

Dr Peter Crooks (British Dental Association Northern Ireland):

I am the chair of the Northern Ireland dental practice committee, which represents all general dental practitioners throughout the country, not just in one area but in every community in Northern Ireland. I also thank you for your invitation to this Committee session. As I have heard this afternoon, members deal with many issues and spend some time on them, and I appreciate the fact that you have taken time to invite us.

We are not in the business of saying no to these regulations. From the outset, I wish to say that we are not saying no all the time. Every dentist in the country accepts that there has to be regulation of all healthcare sectors, including the public and independent sectors, for various reasons, to keep standards high. That is what we want. We are proud of our profession and want to keep our standards high. We want to improve standards still further, and inspections help us to do that. They set the bar, and we do our best to jump over that bar. Most importantly, they also ensure patient confidence in the sector, which is also what we want.

However, the big "but" is that we want regulation and inspection to be proportionate and for it to take into account the small establishments in which we work. The regulations put dental practices into the category of "independent hospitals". I am sure that, when each one of you goes to your high street dentist, you do not think that you are going to a hospital. It is simply not like that, and we feel that we have been shoehorned into an inappropriate category.

The reason for that categorisation is that, in a mixed practice, we provide private dentistry. We could provide 99·9% of our dentistry through the National Health Service (NHS), but, if we were to provide a mouth guard for a child who required it for playing contact sport on a Saturday morning, it would not be provided by the National Health Service. I do not see that that would suddenly turn us into a hospital.

In these days of increased expectations from patients, they might want a white filling on the biting service of a back tooth, and the Department of Health, Social Services and Public Safety (DHSSPS) might state that it cannot provide that on the Health Service. Therefore, if we were to

provide such treatment, we would have to do so privately, but that would not suddenly mean that we were working in an independent hospital. It seems totally inappropriate and should be looked at again.

Being considered to be an independent hospital will put an onerous regime on us, and it will allow for a fee to be levied on us, which will also be onerous. That is of great concern to my colleagues, and I have heard that stated many times in various dental meetings. There is much duplication in the process. Dental practices are already inspected by the Health and Social Care Board, probably about once every three years or so. We are already inspected by one set of folk, and these regulations are asking the same dental practices, the same dentists, the same protocols and the same processes to be inspected by another organisation. That adds an extra layer of bureaucracy onto dental practices.

I will give an example of duplication. The Department and the Regulation and Quality Improvement Authority (RQIA) have already run a couple of evening events at which inspection of our radiology processes has been discussed. They are the Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2000 (IR[ME]R). I will not bore you with all the details, but we have already spent two evenings in a nice hotel talking about how we will be inspected and how we will keep up with those IR(ME)R regulations. In February 2011, the RQIA will send a representative to a course at which he will talk about those IR(ME)R regulations.

Lo and behold, we are already inspected on how we comply with the IR(ME)R regulations. In my practice, my file has recently been reviewed by the radiation protection division of the Health Protection Agency in England. It inspected me against the Ionising Radiation Regulations (IRR) and the IR(ME)R regulations, whereas the RQIA had told the dental practice committee that no one else was inspecting us on the IR(ME)R regulations. Therefore, there is duplication, or, if we do not wish to use that word, repetition. That is the way in which we are being inspected. The General Dental Council (GDC) also keeps an eye on us. We have regulations to fulfil for it, not least about complaints, even in private practice.

What are the advantages and disadvantages of these regulations? As I said, the advantages are to do with keeping standards high, further improvement and ensuring patient confidence. The disadvantages include the fact that some of those inspections are already in place and that there is

an effect on patient care. If more people come in to inspect us, we have to take time with those inspectors, perhaps two or two and a half hours. That is two and a half hours less patient care. There is also the quite onerous cost, which will ultimately be passed on to patients. The economic climate is difficult, and we do not have a money tree in the back garden from which we can pick money. Ultimately, it will have to be paid for by patients or constituents.

I will sum up the reality for dental practices. I represent dental practices throughout the North of Ireland, and by and large my colleagues work in small establishments with fewer than four approved places, as they are called in the regulations. In other words, they have fewer than four dental chairs. That covers the vast majority of dental practices throughout Northern Ireland. We want to be regulated appropriately and proportionately, and we want to be charged appropriate fees. As the regulations stood, as a small establishment, we would be charged £261 a year. The DHSSPS appears to want to charge almost four times that amount. Perhaps the Department will quote what happens in England or Scotland. For all I know, perhaps it will quote what happens in France or Australia. However, we are not worried about those countries. We have been invited here because the Committee oversees health services in Northern Ireland, and we represent dentists in Northern Ireland, so I am concerned only with Northern Ireland.

To sum up: we are mostly small businesses; we all work in a difficult economic climate; we employ thousands of staff throughout every community in Northern Ireland; and, on top of everything else, the legislation will be a significant bureaucratic, regulatory and financial burden on us. Thank you very much for listening.

Ms Christie:

I want to pick up on Peter's point about duplication. In the Department's response to the outcomes of the consultation, it stated that there would be protocol arrangements between the RQIA and the Health and Social Care Board to ensure that practices are not overburdened with multiple inspections. Just talking about being overburdened with multiple inspections is, in itself, recognition that there will be multiple inspections, and every inspection disrupts patients and business.

Furthermore, the Department also agrees that regulation should be proportionate, with which we all agree. However, the legal advice received by the Department confirms that it will be unable to rationalise inspections between the Health Service and private sides, so that appears not

to be an option in the present legislative arrangements. We appear to be faced with a duplicitous regime, and we have no evidence that duplication can be avoided. Of course, that brings us back to the main concerns around patient care, business and bureaucracy, all of which has to be paid for and supported.

Mr Seamus Killough (British Dental Association Northern Ireland):

Speaking personally, I think that it is ironic that I tick so many boxes in the legislation. I run a single-handed practice in a medical centre in Cushendall that delivers various healthcare systems, including four medical GPs. For 37 years, I have ticked every box and delivered everything that is required of me, including dealing with health and safety officers and radiation protection advisers, being inspected by the Fire and Rescue Service and complying with electricity regulations. My practice is solely NHS, which means that more than 95% of my income is derived solely from delivering NHS dentistry. Yes, there is a nod to treating my grandchildren, other people's children and adults who play contact sports, but my major focus will always be on delivering Health Service dentistry.

Under these regulations, someone who comes into that health centre and walks down a corridor to get to my surgery would be going to an independent hospital. The next day, if that person has a bit of a cold and comes in the same door but turns right to go down the other corridor to the four GPs, he or she will not be going to an independent hospital. I find it baffling for dental surgeries to be classed as independent hospitals, with all the associated rules and regulations.

We are governed — rightly so — by Health and Social Care Board regulations and by our own health and safety small business regulations. It is all there. For that 2% of income from private work, I have now been classed as a private concern and as an independent hospital, and I will have another burden of inspection and regulation to take on board. What will suffer as a result? The care of our patients will suffer, because inspections take time. I cannot understand the reasons behind the regulations. After 37 years of delivering Health Service dentistry, I am considered to be healthy, safe, and delivering an excellent service. That is replicated throughout Northern Ireland.

As Claudette said, the nature of the dentistry that is delivered in Northern Ireland is a mixed NHS/private concern. The legislation should be solely for the private delivery of dentistry; there

are only five to 10 such practices in Northern Ireland. The legislation also states that dental practices will be visited once a year. My personal view, as a practice owner, is that that is baffling. There are 356 practices, and it will be very difficult to visit all of those in a year, unless there is a massive workforce.

The Chairperson:

I assume that you have seen the draft of the evidence that we took on 24 June. You will note that the Department explained why dental practices are defined as independent hospitals. That was the only way in which it could draw up the regulations without amending primary Orders and Acts. It was a hook on which to hang the regulations. The Department is not defining dental practices as independent hospitals; it is simply using the regulations that would apply to independent hospitals in order to avoid primary legislation so that it can carry out inspections and regulation. Even the Department realises that it is a bit like using a sledgehammer to crack a nut, but it is not treating dental practices like the independent clinic at Malone or the North West Independent Hospital or anything like that.

Ms Christie:

We have no guarantee of that. Once something is set down in legislation, it will happen as the legislation and the directions set out.

The Chairperson:

How do you get around the difficulty of people working extensively as private dental practitioners but doing the odd bit of NHS work? Does that mean that they are excluded from all the regulations?

Mr Killough:

No, definitely not, but, by definition, if they are doing Health Service dentistry, there are — rightly so — rules and regulations requiring them to have NHS contracts to which they must adhere. That is the same for all of us, which happens to be the majority of the dental profession in Northern Ireland. There is no way that, simply because someone does 90% private work and 10% Health Service work, he or she should not have the same standards for delivering the service.

The Chairperson:

Do you see the regulations as applying only to the very small number of practices that are purely private?

Mr Killough:

Yes. The RQIA is currently responsible for going to the Health and Social Care Board to check that what is being delivered by the Health Service is in keeping with standards. Therefore, why are there two or three additional pieces of legislation to do the same thing?

The Chairperson:

You mentioned costs, and the Committee asked the Department about that. It will charge you £990 in the first year and then £46 per chair. I think that most of you are two- to four-chair practices. In other words, it is like a golf club; people pay an upfront fee in the first year and then an ongoing membership fee. Two hundred pounds a year does not strike me as being a huge amount of money to pay for regulation.

Dr Crooks:

However, we are already paying the Public Health Agency, for example. My last bill was for £700, which covers three years. General Dental Council fees are also going up considerably. It is quite nice for the Department to say that it will charge £940, but it does not have to find the money in this day and age, when costs are increasing and allowances from the Health Service are decreasing.

The Chairperson:

The figures for National Health Service dental claims have been published, and we saw them. In Londonderry, there was one claim for £720,000. Even in my constituency, a dentist in Downpatrick made a claim for £300,000 a year. It was eye-watering stuff. Given those types of figures, are you telling me that £900 will be a problem?

Dr Crooks:

Not for those folk. Are those the figures that were published in the 'Belfast Telegraph'? A retraction had to be made, because the figures were not right.

The Chairperson:

The figures were incorrect by around £60,000, so those dentists were bringing in only some £660,000.

Ms Christie:

With respect, Jim, the headline figure that you quoted was retracted by the Health and Social Care Board's Business Services Organisation (BSO). That figure was inflated by 73%, we received a retraction, and a public apology was issued in the 'Belfast Telegraph'. It is highly important to note that that was incorrect.

The Chairperson:

There are still many National Health Service dentists in Northern Ireland who earn more than £100,000 a year through National Health Service dentistry.

Ms Christie:

The important point that we are making on the draft legislation is that dental practices, because they are based in small communities and towns and are finite in what they do, are small. The original draft of the legislation included a clause that enabled a small establishment to have a fee applied to it that reflected that. The redrafted legislation has removed that so that all dental practices must be regarded as, and pay the same fee as, an independent clinic, such as the independent clinic at Malone to which you referred. There is a big difference between the turnover that might be expected from a high street dental practice that makes a few gumshields for children who play sport and the turnover that might be expected from the independent clinic at Malone.

The Chairperson:

Would you be satisfied with a tiered charging system that reflected the positions of small dental practices, such as Mr Killough's, up to the big players that bring in a great deal of private money, or are you concerned about the principle?

Ms Christie:

That would be helpful.

Dr Crooks:

It would be a good start. It had been pointed out that the fee for the small establishments should

be something like £261. The money is not the primary concern. The money that goes out of the surgery is gone. We want to have money coming into the surgery to improve patient care.

Mr Killough:

Do we want duplication? Are we a safe profession? Of course, I am biased, but we are one of the most professional healthcare organisations in Northern Ireland. We are up there with the very best. Do we need another tier of regulation for the vast majority of dentists who are already regulated? Do I need to be asked exactly the same questions and to produce this and to produce that? Must I turn up to see this and that when I have had a contract for 37 years to deliver Health Service dentistry. It seems convenient to multiply £962 by the 360 practices to create a source of revenue of some £300,000. It that, for example, simply to check my place for two or three gumshields? Am I a threat to society? Will I suddenly change my method of delivering dentistry because it is private and, therefore, needs to be checked?

The Chairperson:

Mr Killough, I will not name any individuals, but you will be aware of a court case that has recently concluded in which there was serious malpractice in a dentist's practice in the north Antrim area.

Dr Crooks:

With respect, that has not gone to court yet.

Mr Killough:

With respect, is there any walk of life or profession of which we can say that it does not have one such example?

Dr Crooks:

That case is absolutely reprehensible, but it has nothing to do with today's discussion.

Mr Killough:

Should I say to my children, who are primary-school teachers, that they are responsible for Hitler because he went to a primary school?

The Chairperson:

The serious point is whether the implementation of this type of regulation could pick up on abuse or problems that arise more effectively than the present system.

Mr Killough:

No.

Dr Crooks:

The two murders took place outside of the dental practice. It has nothing to do with the issue. There is a forthcoming case on which I cannot comment because I know nothing about it, and regulations might impact on that. We want the regulation to be proportionate but not excessive and not duplicated. If I am already being inspected by someone else, why can I not send in a certificate to evidence that, without having to go through an extra layer of bureaucracy? That would seem to be a common-sense approach.

Mr Easton:

I will probably get into trouble for saying this, but I will do so anyway. I am sympathetic to what you are saying, unless I am convinced otherwise. It is not that I have a problem with your being checked up more often. However, in my view, you are already being assessed under the NHS, and you are being regulated and checked. I do not see the point in your being double-checked just because you have a wee bit of private business. I could understand that happening if 50% or more of your business was private. Perhaps we should consider different layers of regulation.

Dr Crooks:

Would you like to sit here?

Mr Easton:

If a practice is 90% or 98% NHS business, why does it need to be regulated because of the other 10% or 2%? That is duplication, which is something that the Health Service should be trying to do away with.

I am sympathetic to your argument, unless something changes my mind. I see your point, and perhaps the way to resolve the issue is for the Department to consider a layered approach.

Mr Killough:

On another point about the responses from the Department, the RQIA asked why it could not take over the role of the boards and carry out NHS inspections. This new legislation deprives it of that function. As Claudette said at the beginning, the Department has stated that legislation does not permit that. Therefore, by definition, it is accepted that there are two layers.

Mr Girvan:

I, too, appreciate the issue of possible duplication. This probably goes against everyone's view, but we have the highest regard for what the RQIA does in private nursing homes and other areas. The Committee was involved with the RQIA recently, when it was involved in a full review of a case, which it carried out very effectively.

My difficulty is with duplication. If you are already regulated, why should that be done again? Therefore, there is merit in looking at the possible cost implications not only to your members but to the RQIA, as it will have to employ additional staff to undertake that work. We need to see the total picture. Unfortunately, regulations are brought forward — I am speaking off the cuff here — and they create work for themselves and for other areas too. If I was running an organisation such as the RQIA, I would try to regulate everything, and I would ensure that I got that work, because it would benefit my back pocket. That is possibly one area that must be considered. I would like to see how the case for regulation was brought forward in the first place.

Dr Crooks:

I had your words written down, but I did not get to say them: the RQIA is creating work for itself and creating bureaucracy.

Ms Christie:

It is important to note, however, that there is a gap in regulation. We are very clear about that, and where a regulatory gap exists, it must be filled. However, the regulation must do what it sets out to do in the most proportionate way possible. We are clear that regulation is not only important; it is imperative for public confidence.

Mr Gardiner:

Are the majority of dentists now in private practice?

Mr Killough:

No. The majority of dentists deliver NHS dentistry.

Mr Gardiner:

I question that, because it can be difficult even to get an appointment. I know of a person who broke a tooth while his dentist was on holiday. The surgery referred him to another dentist, who told him that, as the surgery had already taken one of his dentist's patients, he would have to ring round others. It was I who had to go through those hoops, so I know what I am talking about. I tried another dentist, who said that the practice did only private work. I ended up going to Craigavon Area Hospital to have the tooth dressed until my dentist came home. He sent me to a clinic in Newry, and the treatment cost about £200.

Ms Christie:

It is important to note that dentists are a finite resource: they have a chair at which to operate and two hands to operate with. Dentists undertake to provide care for their cohort of patients, and their diaries may be full as a result of looking after them and meeting their needs. If someone else comes along asking to be looked after, how can the dentists accommodate that individual when they are already committed to dealing with a finite group of people? Given the finite resource of two hands and a single surgery, a dentist cannot deal with everyone, because, by the very nature of the job, he or she cannot listen to more than one person at a time. Should dentists tell their patients that they cannot see them? Should they decide to see 2,000 patients instead of 1,000, which would mean longer intervals between appointments? Those are the difficulties in which dentists find themselves.

Mr Gardiner:

The person who will have to wait longer will probably be the one who is not paying you privately. I am sorry, but that is the image that I have of dentistry, and I am disappointed to have to say that.

Dr Crooks:

Although I am a bit wary of BSO figures, they show that 900,000 people are registered as NHS patients in Northern Ireland.

Mr Killough:

As a profession, we are very proud of the service that we deliver under an NHS contract. For example, in my area, there are four GPs and one dentist, and, therefore, there are times when people cannot get an appointment to see that dentist. What happens when 20 people are already waiting and someone else arrives and wants to go in first because he or she has not seen a dentist for four years? That is the reality. I disagree with your view of dentistry, Mr Gardiner. Statistics show that, in Northern Ireland, 900,000 people receive NHS dentistry from 350-odd practices.

The Chairperson:

On a slightly different point, if, as a private customer, I pay to have my teeth done and it is expensive, should I not expect a higher level of supervision and regulation?

Mr Killough:

I deliver NHS dentistry to my patients. As a professional, should I lower the level of care just because somebody gives me more money?

The Chairperson:

I am thinking more of a situation in which, having just forked out £3,000 or £4,000 for dental work, rightly or wrongly, I might expect very high supervision of that work.

Mr Killough:

Would you expect the Health Service to do that work?

The Chairperson:

I could not get some of that work done in the NHS.

Mr Killough:

All my life, I have driven a Datsun: the greatest car in the world. Some people drive a Mercedes. That is their choice.

Dr Crooks:

There is no problem with regulation or inspection per se, but there is a problem with doing it twice in the same place.

The Chairperson:

Is there any evidence that more inspections are about greater rigour, or are they charge generators?

Ms Christie:

It is important that the minimum standards are the same across the board. There can be any maximum standard, but all dentists must meet an absolute minimum standard.

Dr Crooks:

The RQIA inspected my surgeries in relation to sedation. The inspection was very good and proportionate, and it helped us with our standards. We want to ensure that that continues.

Mr Killough:

However, that already happens; that is the status quo.

Mr Callaghan:

You may not know me. I am Pól Callaghan, the new SDLP Member for the Foyle constituency. Having read the papers, I have two questions. You state that the vast majority of practices have four or fewer chairs. What proportion has more than four chairs?

Ms Christie:

I cannot give you a figure off the top of my head, Pól, but it would be low. The vast majority of dental practices are small businesses.

Mr Callaghan:

It might be helpful if there was a way that the number could be identified and the Committee could have that information. From what I can make out from the transcript of the previous departmental and RQIA presentation, the Department does not appear to have figures for the number of private patients. You gave a figure for the Health Service. Does the BDA have the figure for the number of private patients in Northern Ireland?

Ms Christie:

That figure would not be picked up, because each individual practice is different.

Mr Callaghan:

That was just an enquiry, because I know that you have been gathering evidence, and I wanted to test that while you are here. You are clearly saying that you recognise that there is a regulatory gap. How do you propose that the gap is closed?

Ms Christie:

The gap that exists is that purely private practices do not have to meet the same requirements of inspection and legislation as practices that offer any Health Service work. Remember that, on 31 March, according to the figures that I quoted, 356 practices in Northern Ireland delivered some, any or lots of Health Service provision.

Mr Killough:

As the end of our briefing states:

"The purpose of this legislation should be to focus on solely private dental practices."

The number of such practices is no higher than 10.

Mr Callaghan:

What about the private work that is done in, for want of a better phrase, the mixed sector? What do you propose should be the approach of the Committee and the Department? It seems to me that the regulatory gap is not simply a geographically determinable gap between practices. Rather, the gap is one of activity. Your position, to some extent, is based more on where the gap exists rather than what activity the gap covers or does not cover.

Mr Killough:

The legislation covers the rules and regulations attached to the practice. If you are talking about the quality of work that is delivered, within Health Service practices, for example, there are regulatory referral dental officers RDOs and inspectors. In the private sector, there are completely different rules and regulations. If patients are dissatisfied with their treatment, the private sector has the General Dental Council, the small claims court and the law to take on board.

Mr Callaghan:

If there was a change of position and the Department was to say that the RQIA will take responsibility for the entirety of the regulatory system in dentistry, what would your approach be

to that?

Dr Crooks:

That would be easier, although we got the impression that, legally, the RQIA cannot do that.

Mr Killough:

Legally, it cannot do that.

Mr Callaghan:

I understand the legal point, but the law can be changed.

Mr Killough:

As with everything else, there would be consultation with all of us in setting that up. In my opinion, every case of regulation should involve correspondence between everyone to try to get suitable regulation that is in the best interests of the people with whom we are all concerned first and foremost — the patients.

Mr Callaghan:

The Chairperson talked about a tiered system of finance, which seems to have some sense behind it. In a way, the system is tiered already, in one respect, in that the per-chair annual fee is, effectively, tiered, because the greater the number of chairs in a practice the greater the fee that would apply.

Ms Christie:

However, that is not the case. That was the position in the draft legislation, but our understanding is that that has now been removed and replaced by a single fee. The legislation, as originally drafted, recognised that an independent hospital could comprise a small establishment, to which a different fee would apply, or a large establishment, to which a single fee would apply. Now, only the single fee remains.

Dr Crooks:

However, the ongoing annual fee is £46 per chair.

Mr Callaghan:

I was talking about the annual fee. Correspondence from the Minister, from two weeks ago, refers to an annual fee of £46 per chair, but your issue is that of a tiered system applying to the initial fee.

Ms Christie:

Yes.

Mr Callaghan:

Finally, I am in the dark on the issue of independent hospitals. I understand your position, in that you are not an independent hospital. Peter, you talked about an onerous regime and a serious burden. However, I am not entirely sure what that burden would amount to over and above what you experience through the HSC board regulatory process? Will you identify that additional burden, because if you are saying that the measures are not proportionate, we need to know your view? To be honest, I am not entirely clear about what the disproportionality is in your eyes.

Ms Christie:

A raft of additional requirements would apply to independent hospitals, such as having to have a registered manager, having to demonstrate that persons are fit to practise — we already have persons who are fit to practise, because everyone who works in a dental practice is a registrant of the General Dental Council — and meeting legislation that requires annual accounts to be sent to the RQIA for scrutiny to ensure that the business is viable. Although I cannot quote them all, certain requirements would be applied in several areas. The point was made that dental practices should fit into that category. However, once the requirement is in legislation, the RQIA will have no choice other than to apply the legislation to the letter. Therefore, if the legislation requires notification of a specific aspect, the RQIA will seek such notification.

Mr Killough:

The 2005 regulations contained a list of exceptions to the term "independent hospital", which included our primary medical practitioner colleagues, patients' homes and sports grounds or facilities. They are considered as walk-in primary care facilities. As I said, in Cushendall, if I walk down one corridor, I am in a walk-in primary care facility, but if I walk down another corridor, I enter an independent hospital, with all the extra rules and regulations attached to delivering Health Service dentistry, which, along with a little private care, is what we all do.

Dr Crooks:

Some good ideas have been put forward, such as tiered initial fees.

The Chairperson:

John McCallister has been trying to get in. He might portray this as a deliberate attempt to keep him quiet, but I have just not been able to get to him.

Mr McCallister:

It is obviously discrimination in the run-up to the election.

We are all trying to get our heads round this issue. Presumably, if the inspection regime for dentistry in Northern Ireland could be standardised across the private sector, the Health Service and mixed practices, you would be agreeable to that.

Dr Crooks:

That would be sensible.

Ms Christie:

I think that that will happen.

Mr McCallister:

That would be eminently sensible. I do not think that my dentist's practice is purely private, but it should not be regulated any more or less than other practices; regulation should be standardised.

Coming from my background in agriculture, I have some sympathy with you on the duplication of inspections. How can we cut out that duplication? Does the current inspection regime involve just a one-day visit to inspect everything, or do several visits take place over the year? Could you end up with not only two different groups inspecting practices but a multiplication of their visits? How will inspections be carried out under the new regime?

Dr Crooks:

I run two one-chair dental surgeries, and, at present, each inspection takes about half a morning. Obviously, in bigger practices, they take longer. If the inspection regime becomes more onerous,

particularly given the future decontamination requirements, inspections will take considerably longer. We have come to you because we are not sure about the future. We want things to be kept as simple as possible, but we envisage two sets of people coming in to inspect our processes and so on; whereas, I would be quite happy with only one. I am not sure whether I responded to all of your questions.

Mr McCallister:

Are there different elements to those visits? If you clear an inspection, is that you for another year, three years, or whatever?

Mr Killough:

Yes.

Mr McCallister:

It is not the case then that inspectors examine one element of the practice one day and come back six months later to inspect another?

Mr Killough:

The RQIA has that facility through the HSC board. For example, as Peter mentioned, the RQIA focused on IV sedation in Health Service dentistry. It targeted various surgeries that deliver IV sedation. It checked them, found out what was —

Mr McCallister:

Was that done on a random basis?

Mr Killough:

The RQIA picked a certain number of surgeries, perhaps fewer than 20. It still has that facility to select a number of surgeries and check certain elements of their work. That is the current status. The point is that that must happen because, according to the board, the work of the RQIA will not overlap with its responsibilities. Therefore, the board carries out its responsibilities, and then we will also have the RQIA checking our private income.

Mr McCallister:

I am keen to avoid random inspections for this and that, particularly for a specialism as specific as

the one to which you referred, because that could lead to continual inspections. I presume that an element of preparation is required for half-day inspections, such as having no surgery that day.

Dr Crooks:

There is no surgery for that half morning or so. It is a bit like a school inspection. The RQIA can make recommendations, which we do our best to fulfil, and it could come back to check that those recommendations have been fulfilled. That is absolutely fine, as it is intended to keep up the standards, but I, like you, do not see the point of having two sets of people inspecting the same thing.

Mr McCallister:

Has the current inspection system highlighted any major problems in dentistry? Has anybody been —

Ms Christie:

I am not aware of any. The Health and Social Care Board inspects practice premises, but, as we have found out through the consultation and process, it is not legally obligated to do that on the Health Service side, although it does. In the past, routine inspections have been carried out over a rolling cycle of three years. However, every practice on the Health Service side must meet a series of obligations in respect of clinical governance, practice management, managing complaints, managing radiation protection, health and safety, decontamination, and so on.

Mr McCallister:

I take it that none of those areas require inspection under better regulations?

Mr Killough:

As with any small business, we are open 24 hours a day for anyone to come in to the surgery to check. Health and safety officers can come in from the high street and check at any time. It is not a healthcare issue; we are small businesses that deliver healthcare.

Mr McCallister:

Other small businesses should have some element of protection. Good regulation should look at what businesses do, what outcomes they want to achieve and whether regulation places an unnecessary burden on them.

The Chairperson:

The difference between farmers and dentists is that dentists do not receive a substantial single farm payment — *[Laughter.]*

Mr McCallister:

I would happily swap my single farm payment for Seamus's modest lifestyle.

The Chairperson:

In case I ever get a toothache in Cushendall, we were playing devil's advocate. I would not want to be sitting in a dentist's chair some day and for this all to be brought back or questions asked.

Mr McCallister:

I would suggest no anaesthetic.

The Chairperson:

The questions are designed to tease out answers rather than statements.

Mr Killough:

We are a caring profession at all times.

The Chairperson:

Thank you very much. We will be equally tough with the Department. We will ask it searching questions and tease out the issues. Basically, you are telling us that you want us to pray against the regulation.

Mr Killough:

As it stands, yes.

Mr Girvan:

Would it suffice to say that you are happy enough to accept that for 100% private practices?

Dr Crooks:

Yes, but for none other.

The Chairperson:

I thank the witnesses.

Dr Crooks:

We thank the Committee for our 10 minutes: they were the longest in my life.

Mr Callaghan:

Luckily, we do not charge.

The Chairperson:

I welcome the departmental officials to the Committee. They include Dr Jim Livingstone, who is the director of the safety, quality and standards directorate. Dr Livingstone has previously appeared before the Committee, as have Mr Donncha O'Callaghan — I hope I have got that right —

Mr Donncha O'Carolan (Department of Health, Social Services and Public Safety)

O'Carolan.

The Chairperson:

Mr Donncha O'Carolan, who is the Chief Dental Officer, and Mr Billy Baird, also of the safety, quality and standards directorate. The officials have heard the BDA put its views pretty forcefully. The association remains extremely unhappy. Nothing has moved on the issue since June. The BDA was not satisfied with the Department's evidence then or deliberations since. You have 10 minutes in which to make a presentation, after which members will ask pertinent questions.

Dr Jim Livingstone (Department of Health, Social Services and Public Safety):

For the record, I have a dental appointment on Tuesday next for two extractions. Therefore, if I quaver, members will understand why. *[Laughter.]*

Mr Gardiner:

Is it private? Will you have to pay for it?

Dr Livingstone:

I have not worked that out yet; however, it is good to be with the Committee again. We last met to discuss this issue in June, when the Committee approved making the statutory rule, on the condition that on completion of extended consultation officials would return to members. We extended that consultation and, at the Committee's suggestion, met the BDA for discussions on 26 August. Frankly, I am disappointed by the BDA's response to our discussions and the fact that we do not seem to have found a better common understanding.

I will say a few things without going through all my notes, because we have listened to the BDA's evidence, and I know that the Committee's time is precious. First, this is about patient safety: it is not about raising money or bureaucracy, but patient safety. It is not even about preventing harm to patients because that may happen at some time in the future. It has already happened. Patients have been harmed; in very few cases, thank God, but it has happened. Therefore, we should not assume that this is all about putting in place bureaucracy for its own sake just in case something might happen: these things have happened, and we have a duty to ensure that we have a regulatory system that protects patients and improves quality. That is what this is about.

I want to clear up the question of duplication. I entirely agree with the BDA and colleagues here that the last thing that we need in the future is duplication of resources, effort or anything else. I assure members that that will not happen. The focus is on private dentistry rather than private practices, and virtually every patient, at some stage, will be private.

Thus, in reply to Mr Gardiner's earlier question: I am not sure whether I will be private or NHS next week. I do not know whether the public realise that, when people get a filling, a dentist may ask whether they want a white amalgam or an old-fashioned grey one. If people opt for a white filling, they are private straight away, and they pay for that. That makes the patient private. Therefore, it is a little bit disingenuous for the BDA to talk about "wholly" private practices. There is hardly a practice in Northern Ireland that could define itself as wholly NHS. In general, we are dealing with an extremely good, high-quality service, but it is a large, complicated service in which a great deal of the service is provided through private as well as public means.

We have designed a means of putting in place regulation and inspection backed by the strength of legislation. Please note that there is no legislative requirement on the Health and

Social Care Board to inspect. That simply does not exist at present, and the inspections happen up to every three years between practices. Cars are inspected more often in Northern Ireland, and that is for reasons of safety. This is about safety and about ensuring that standards are up to date.

The Chief Dental Officer will say a few words on that, because we have produced minimum standards for dentistry. Every practice will be inspected against those standards and will be inspected only once by the RQIA. There will not be an additional inspection by the board; I can assure the Committee of that, because the board is more than happy to let the RQIA conduct those inspections. The only occasion on which the board will set foot in a dental practice for inspection purposes will be when the RQIA has called it in because there is a problem with a particular practice, or when, in extraordinary circumstances, there is an exclusively NHS practice. As I said, that is difficult to find. There will be no duplication; I can assure you of that.

The quantum of fees is tiered, because it is charged on a per bed/chair basis. In other words, an independent hospital will pay an awful lot more every year, because it will pay £46 per bed. A dental practice will pay £46 a chair, and for many cases that will be £92. If dentists want to pass that cost on to patients, it will be private patients to whom that they pass it. I do not think that many patients will notice the difference, but they will notice that they have a well-regulated service that they can be assured is safe and delivering services to an appropriate quality.

My colleagues from the BDA said that the Department will probably quote fees from elsewhere. I will say two things about that. The fees in England are £1,500 per bed or chair, not £46. I also note that, under Treasury guidelines, we are required to work towards full cost recovery for regulatory inspection. We are a long way from that in Northern Ireland, and we constantly keep fee regimes under review, which is our duty. I emphasise: there will be no duplication. There will inspection to a common set of standards that apply whether the dental service is private or public. That is what the RQIA will inspect against once a year, and it will go in again only if there is a problem. I think that that is what people would expect to happen.

Mr O'Carolan

Thank you for the opportunity to address the Committee today. I will pick up on a couple of points that Jim made. Like Jim, I am disappointed that the BDA has taken the position that it has, given that we met its officials in August to explain the various issues that Jim raised. It is about patient safety; it is not about incidents that might happen. We have to look only at the recent

past. Not too far from here we had the Kelso case in Newtownards, which left many private patients disadvantaged because they had no protection under regulation.

In 2007, we had the John Tan case in the former Northern Health and Social Services Board area. That practice was a mixture of Health Service and private patients. The only recourse for private patients was through the courts, whereas Health Service patients at least had recourse through various institutions. In another recent case, a dentist was suspended by the GDC. He had been practising under the Health Service, and we had great concerns about him. He subsequently practised privately, and we had to use the RQIA and the GDC to remove that individual.

Seamus says that we should be regulating only private practices, but all the cases that I mentioned happened in the past couple of years in mixed practices. We had no regulatory authority over the private patients in those practices. I want to pick up on a point that Pól Callaghan made, because he really hit the nail on the head. There are only a small number of purely private practices in Northern Ireland. I agree with Seamus, that there are probably only around 10 of them. If, for example, those practices have 1,000 patients each, that is 10,000 private patients. As Pól said, the vast majority of them are treated in the mixed sector. There were 375 dental practices at the start of October — let us call it 400 in order to keep the numbers simple. If each of those practices has 100 private patients, that is 40,000 private patients who, if we adopt the BDA's position, will have no protection. The only way to protect all those patients is to regulate the entire sector.

I reiterate what Jim said: there will be no duplication. Although, legally, the RQIA cannot act on behalf of the board, the inspections and their outcomes are public information and can be shared with the board. We explained that to the BDA and discussed it with the board. The board and the RQIA are working on a set of protocols so that they can use the information that has been gleaned from RQIA inspections on the Health Service side. Therefore, there will be no duplication of effort on that aspect.

Peter said that, under the radiation regulations, he has been inspected twice. I will go back to Jim's analogy about cars. We all have to take our cars for an MOT once they are over four years old. It is exactly the same for radiation regulations. The mechanic inspects the car, and a person pays the mechanic. The person then takes the car to the MOT centre and pays another fee for an inspection to ensure that the car meets the public standard. The same applies to the radiation

regulations. A person selects an organisation and pays it to make sure that all the equipment meets the standard. The RQIA will then ensure that that person has the necessary documentation. That is not duplication. It is public assurance, because the dentist pays another organisation to act on his or her behalf.

The fees are not onerous. The Chairperson quoted dentists' incomes from last year's figures, and I saw his comments in the press. Some of the figures were inaccurate, but the vast majority were not. However, leaving the BSO figures aside, the average income for a practice owner in Northern Ireland is £123,000 a year. That figure comes from HM Revenue and Customs, not from the BSO. Therefore, £92 a year is not an excessive fee, particularly given what people pay in England. I am happy to take any questions from the Committee.

The Chairperson:

I am sorry about the confusion with your name; I mixed you up with an Irish rugby player. I think that there is a player called Donncha O'Callaghan.

This is a difficult issue, because the representative body of the vast majority of dental practitioners in Northern Ireland is saying one thing whereas the mandarins in the Department and in the high-powered Civil Service are saying the direct opposite. We are left in a bit of a quandary. Is there no way to merge the present scheme for the protection of National Health Service patients with that for private patients? In other words, is it absolutely impossible for the inspection that covers the ordinary three-year period for a National Health Service list to look over the wall and inspect the private work as well?

Mr O'Carolan:

We will soon publish a set of standards that are common to the private sector and the Health Service. The RQIA will inspect every practice in Northern Ireland by default, because it inspects them on the private basis. Therefore, it will automatically inspect them against the exact same set of standards that apply to the Health Service side. The Health and Social Care Board will simply lift that information and, if there are problems, will drill down further. If there are no problems, they do not have to inspect. Therefore, we have a compromise position whereby, by default, the RQIA will be able to provide the same information for the private side and for the Health Service side.

The Chairperson:

Dentistry is a mixed profession. Northern Ireland is not like England where there are hundreds of Harley Street-type private dentists. If an inspection on the NHS side is done properly, it is surely bound to show up any problems in the private side given that there is so much overlap.

Mr O'Carolan:

There is absolutely no statutory requirement on the board to do that. In fact, in the east of the Province, the board has not been inspecting regularly because of staff shortages. The board has told us that, because the RQIA will do the inspections, it will stop practice inspections to avoid duplication.

Dr Livingstone:

The Chairperson's point is right. However, I could turn that around. If we inspect the private side, we will, given that it is so mixed, inspect everything. There is no question of the board wanting or even having an urge to start tramping around on the same ground. The board is very keen for this to happen. The changes will assist the board because they will give it much richer information instead of it relying on inspections every three years or so. The logic that the Chairperson described is exactly the logic that underpins the approach. In fact, if we can inspect against a set of common standards that applies to private patients and NHS patients, we will have inspected the standards at which that practice is delivering and can share that information with the board. That is the model, and that is why the board is content with it.

Mr Easton:

I am slightly confused. Are you saying that when inspections move to the RQIA, the board would stop its inspections, and, therefore, there would not be two inspections?

Mr O'Carolan:

Correct.

Dr Livingstone:

There would be only one inspection.

Mr Easton:

Therefore, there would be one inspection every year, not two separate inspections.

Dr Livingstone:

To clarify: we may find a situation in which, in one year, the RQIA would go into a practice for its inspection and the board would also go in. That would happen if the RQIA told the board that there was a problem in a particular practice that the board needed to look at.

Mr Easton:

That would be only if the RQIA had picked up a problem.

Dr Livingstone:

That is a different situation.

Mr O'Carolan:

To pick up on your point: if, for example, a practice had 90% Health Service patients and 10% private patients, and if the RQIA picked up a problem, it would say that, because that practice is mainly for Health Service patients, it falls to the Health and Social Care Board to drill down into the problem. If it was the other way round, and the practice had 90% private patients and 10% Health Service patients, the RQIA would drill down into the problem. There would be a memorandum of understanding between the two organisations to divvy out the work if problems were found.

Dr Livingstone:

The follow-up work.

Mr O'Carolan:

The BDA said, and I agree, that there should not be a huge number of problems. However, by going through the inspection, we can at least assure the public that an annual inspection takes place against a bespoke set of dental standards. At the moment, that does not happen on the board side.

Mr Easton:

Therefore, if the RQIA goes to a nice dentist and finds no problems, there would be no further inspections.

Dr Livingstone:

End of story.

Mr McCallister:

When talking about dentistry, I am not sure whether I am allowed to use the phrase "drill down". *[Laughter.]* Perhaps we need to call in Relate and put the two of you in a room together. *[Laughter.]*

Dr Livingstone:

We actually get on very well.

Mr McCallister:

From your perspective, the arrangements would standardise inspections. However, it seems, and you were in the room when I asked questions of the BDA, that you have failed to convince the BDA and dentists that there would not be duplication. How do you persuade them that they would have one inspection a year? Do you anticipate that the average dentist would see no change?

Mr O'Carolan:

I was in practice for 15 years and owned my own practice for 14 years. When practice inspections by the board came in, there was huge suspicion among practitioners, who did not want that to happen. The board picked a handful of practices to go into and inspect, and mine was the first to be inspected in what was previously the Western Health and Social Services Board area. We were then able to say to the profession that the inspections were not a problem. Practice inspections are now accepted by the profession. However, in the early 1990s, when inspections first came in, there was huge suspicion around them, and we are finding the same suspicion around these regulations.

This is a new regime with different people, whom practitioners do not know, inspecting practices. Therefore, there is suspicion among practitioners. However, having spoken to the board on several occasions, I know that it is very keen to go down this route. The board wants to work with the RQIA so that there is no duplication and so that there is a clear understanding of how information is going to be used.

Dr Livingstone:

There will be a written protocol covering that to ensure that there is no unnecessary duplication.

The Chairperson:

Could that be included in the regulations?

Dr Livingstone:

No, that could not be included in the regulations. However, I am very happy to share that with the BDA to ensure that it is clear on the protocol.

Mr McCallister:

Do you see some of the people from the board moving across, rather than new people being trained or retrained?

Dr Livingstone:

We could consider that for the future. However, there will also be other changes, and the consultation raised issues that we need to consider for the future. For the moment, from the point of view of patient safety, this is the priority.

There is also the issue of dental practices being classified as independent hospitals. As I emphasised to the BDA and to the Committee at our previous meeting, dental practices would not be treated as independent hospitals. Dental practices would be classified as independent hospitals but would be treated and inspected as dental practices against the dental minimum standards and nothing else. We are using that classification because the alternative is primary legislation. In the matter of patient safety, we do not think that it is appropriate to wait two years before arrangements are put in place.

Mr O'Carolan:

We have a similar arrangement with the GDC, which has a private complaints scheme. I set up a memorandum of understanding between the GDC and what were, at the time, the four health and social services boards. That was similar to this situation. In a 50:50 case, a memorandum of understanding was written to say who would take the case and who would not. If the case was 90% private, the GDC took it; if the case was 90% Health Service, the board took it. Therefore,

there is already a precedent for memorandums of understanding when dealing with that mixed economy, and it works very well.

Mr Callaghan:

If I may start with Donncha: there seems to be agreement from the BDA side and the Department that the regulatory gap extends to private treatment. The briefing also refers to orthodontics, which was not covered earlier, so I do not know the BDA position on that.

You said that people who were private patients in some of the cases that you mentioned, or in comparable theoretical scenarios, had recourse only to the courts. I presume that you mean for litigation, or compensation, in the event of complaints or treatment going wrong.

Mr O'Carolan:

There were other aspects to that, Pól. If someone is a Health Service patient, for example, we can call in the Health Service record cards and examine them. We were able to do that in the Kelso case, and those patients were then able to follow up and say: "Here is the evidence that I had that treatment." In the private case, the records were destroyed because nobody had the right to call them in. Those patients were left high and dry, and it was then up to them to prove that they had had the treatment. When that is regulated, the RQIA can at least go in, and it has the right to look at record cards.

Mr Callaghan:

I was intrigued by something that the BDA said earlier. It may have been a misapprehension on my part, but the BDA seemed to suggest that the RQIA currently goes into the Health and Social Care Board and inspects the board's inspections. Did I pick that up wrong?

Mr O'Carolan:

The RQIA has two functions. One is to register and regulate the independent/private sector. It also has a responsibility to assure the Health Service sector. That applies to such issues as hygiene reviews in hospitals, in which the RQIA will conduct a thematic review. On the dental side, the RQIA examined intravenous sedation.

In theory, the RQIA could ask the board about how to quality assure Health Service dentistry. The board would then have to be able to demonstrate how it would do that. However, the RQIA

does not have to do that. It has the right and a function to assure the entire range of health and social care services, be that doctors, dentists, hospitals, and so forth.

Mr Callaghan:

As a layperson, it seems to me that there is already some duplication. I understand your point, Donncha, but I am not sure that that is necessarily a great idea in an era when we are trying to minimise the regulatory burden.

Mr O'Carolan:

Against that, Pól, the RQIA may never look at dentistry. It does not have to look at it, but that is an option. It has that power.

Dr Livingstone:

The RQIA is very much part of that quality agenda. It sits as an independent body on which the Department can call to give assurance on the quality and safety of services in trusts, in the board and in the Public Health Agency. We can call in the RQIA and ask it to undertake various reviews. We are talking about its inspectorial responsibilities rather than general inquiries and reviews. However, we can call on the RQIA for an independent view.

Mr Callaghan:

I was not a Committee member the last time that two of you appeared before the Committee. However, I read the transcript and tried to make what I could out of it. There seemed to be some confusion as to whether a two- or three-yearly inspection regime currently applies.

Mr O'Carolan:

There is no requirement on the board to inspect —

Mr Callaghan:

I understand that. What were we talking about then? Was that a contractual entitlement?

Dr Livingstone:

It is custom and practice. There is no requirement to inspect. It can be three years. We are aware of practices not having been inspected for up to four years.

Mr Callaghan:

Do you have statistics about how regularly the current board and its antecedents carry out inspections? Do they report to the Department on how often they carry out those inspections?

Mr O'Carolan:

No, because there is no legal requirement to do it —

Dr Livingstone:

The board cannot be held to account for it.

Mr Callaghan:

Have you asked, anyway?

Mr O'Carolan:

There is a general duty on the board to assure the quality of care of all services that it contracts, including dental services. Therefore, it is up to the board to approach that in whatever way it sees fit. The board may see practice inspections as part of that or may do targeted inspections because it does not have enough staff. In any case of significant problems with private dental work, the first question that patients or their MLAs ask is why that sector is not regulated; that is what we are trying to achieve. As I said, the majority of private dental patients have no regulation.

Mr Callaghan:

I accept that, but you will accept that members have an obligation to try to establish whether any extant arrangements or any part of a proposed regulatory regime are unsatisfactory. The Health and Social Care Board is part of the proposed regime even if it is not the matter of contention at present. I am unsure whether I am happy with the position that the Department is saying, as you have done, that it is up to the board to satisfy itself on quality assurance issues, because that is a case of quis custodiet ipsos custodes. Should the Department not at least ask for reports from the board about its inspection activities?

Mr O'Carolan:

There are other ways in which Health Service dentistry is inspected. There is the referral dental service, through which a sample of patients who recently received Health Service treatment are called in and inspected, and there is also a complaints system. Practice profiles are also

generated, so that if one dentist is doing many more treatments than others, that will be picked up in the BSO, and probity checks will be carried out. Therefore, the board receives a great deal of information on the claimant side without having to go into the practice, yet there is no information on the private side. The board will continue to look at and profile its information systems and its complaint system; the only part that is moving over and that will be consolidated is the physical inspection of premises.

Mr Callaghan:

My final question deals with resources. There was some discussion during the Committee's previous evidence session about the capacity of the RQIA to implement a new scheme. On the basis of what we have been told today, it is clear that there are very few purely private practices in Northern Ireland. If that is the case, it would appear that, if the regulations were implemented as they stand, there would be very little regulatory inspection work for the board to carry out.

Dr Livingstone:

Yes, but very little of that actually happens anyway.

Mr Callaghan:

During a plenary sitting this week, the Assembly discussed the good use of resources. Has the Department evaluated the board's capacity and the impact on the board? Has it also considered the costs to the RQIA to ramp up? On the one hand, we seem to be saying that we are going to ramp up the capacity requirement in the RQIA, while on the other hand, the logical imperative is that capacity in the Health and Social Care Board should diminish.

Mr O'Carolan:

I can answer that very simply. The dental team in the board was dramatically reduced as the result of the review of public administration, and anyone who was nearing retirement was allowed to retire. As it stands, the team would not have the ability to carry out the three-year inspection, let alone the annual inspection. There was a small team of only around 12 or 13 staff, and, of those, three full-time staff members and some part-time staff members have left, with the result that the core that is left has had to double up. Significant and quite dramatic efficiency savings have been made by the board.

The Chairperson:

The RQIA is independent. You can give all the assurances of the day about its activities, but if Glenn Houston and his team decided to do something, they will do it, and we would not want to be in a position of controlling that activity. What guarantee can you give that the RQIA will not undertake a couple of inspections each year?

Dr Livingstone:

First, there will be a protocol in place, and everyone, including us, will know what that inspection regime will be like and how it will operate. Secondly, like every other body, there is a resource constraint on the RQIA. It will have to live within its means, and the manner in which it carries out inspections will have to be developed in that context.

There is no pressure or scope on the part of the RQIA to do more inspections in any sector. If anything, the pressure is on the Department, because the RQIA is asking it for more money.

The legislation governing the RQIA still makes it subject to the direction of the Minister. If, in fact, the RQIA were to go off and do something contrary to the protocol that it put in place, there are powers that would enable the Department to step in and say that such activity went beyond what was required for the purposes of inspection and regulation.

Mr Girvan:

Thank you for your presentation. I want to make a different point about when the regulatory authority gets involved. It was mentioned earlier that it has certain extra requirements, which would possibly mean additional administrative staff. Will there be additional funding to meet those requirements for those practices that are funded totally by the NHS and whose patients are mainly NHS patients? I know exactly what happened with the RQIA in the private nursing home sector. The RQIA set standards, and it set the ratios of nursing staff to patients and of administrative staff to patients. I know how that was delivered by the RQIA. Yet, the funding that was brought forward did not necessarily facilitate the achievement of those standards.

Mr O'Carolan:

I can answer that directly. We have a set of standards, which have been consulted on. Overall, the BDA supported those standards. The regulation does not increase the standard. Exactly the same standards that are expected of the Health Service at the moment would be applied to the

private sector. Therefore, there will not be additional requirement.

Mr Girvan:

That is fine. I am not totally clear about the issue of duplication. I think that Pól was trying to get into the detail of that. Let us say that 10% of a practice's patients are private patients and 90% are NHS patients. You said that the Department has cut numbers to such an extent that it can no longer deliver its existing inspection programme. That suggests to me that the RQIA is being used as an escape route.

I am a great believer in the private market. My point is that private patients have a choice: if a private dentist is not performing, his patients can simply move elsewhere. However, NHS practices take money from people who cannot afford to pay for private dental care. Those patients require protection to ensure that they receive a satisfactory level of service.

Dr Livingstone said that a great deal of statistical information on productivity is already available. We can drill into those figures to show where anomalies exist, such as whether one practice is outperforming another, or whether one practice receives more complaints than others. Has any of that made any difference to the cases that you have identified? Have your actions been reactive rather than proactive? The aim of regulation should be to ensure that there are no problems, as opposed to reacting when they arise. All the cases that you mentioned are already in the public domain, and some of those came to light through complaints rather than through inspection.

Mr O'Carolan:

Many cases came to light through inspection, including the Kelso case.

Mr Girvan:

That came to light because of the level of productivity.

Mr O'Carolan:

It came to light also because of the quality of care.

Mr Girvan:

How can you determine the quality of care without meeting the patients?

Mr O'Carolan:

We can examine patient records, which are a great indicator of the quality of care. We can look at X-rays and the planning of patient treatments. In conjunction with patient complaints, those reveal a great deal. Most of the private insurance companies in America that pay out for dental treatment do so based purely on X-rays and records. As a hell of a lot of information can be obtained from patient records, they do not inspect patients. I go back to your point about private patients being able to vote with their feet. Tell that to some of Kelso's patients: the damage might already have been done by that stage.

Mr Girvan:

I appreciate that there has been abuse, but the system can still be abused. People who are registered as dentists have more at stake, because they have a professional qualification, they are registered to the professional body, and they could potentially lose their licence to practise. If a dentist is found to have breached any of those regulations, that information might emerge. However, in my hometown of Ballyclare, for example, we did not have a single dentist doing NHS work for a long time. They were all private. If asked why they went private, those dentists would say that it was because of the bureaucracy involved in form-filling. It was not because they were bad dentists — far from it — but that they felt that the system was overly bureaucratic in comparison with what they received from it. Therefore, we have to get the balance right.

One group is telling us that there is duplication, too much bureaucracy and that the regulation creates another empire for the RQIA as it continues on its way to becoming a mother ship that investigates everything. However, you are saying completely the opposite, which is that you are doing away with the Department's dealing with any investigations. However, I am aware that other bodies currently carry out investigations into dental practice.

The Chairperson:

Is there a question?

Mr Girvan:

I am making statements rather than putting questions. I will leave it at that, because I know that Mr O'Carolan will want to come back on those two points.

Mr O'Carolan:

I was not sure what the question was. You said that dentists moved into the private sector because of the level of bureaucracy. I argue that they do so because the private market is more lucrative and, I acknowledge, less regulated. Since we introduced the access initiative and established the extra practices in Northern Ireland, and taking into account the effect of the downturn in the economy, there has been a massive return of dentists to the Health Service. They are not returning because of bureaucracy, but purely for market purposes.

Mr Girvan:

You referred to your August meeting with the BDA. You seemed surprised that the BDA was here telling the Committee a different story.

Mr O'Carolan:

The BDA took exactly the same position then. We clarified that there would not be any duplication, that they would not be treated as independent hospitals, that the fees were reasonable and that we would use bespoke dental standards. We explained all that, and we felt that we had clarified the position for the BDA.

Mr Girvan:

It must not have been clear, because the BDA is definitely not happy with what is being presented.

The Chairperson:

Folks, I think that we need Relate. We need a marriage guidance counsellor, because I have never experienced a situation in which two such diametrically opposed arguments have been so clearly put. There does not seem to be any common ground between you and the BDA.

Dr Livingstone:

I am not one bit surprised that the BDA takes the position that it does. It is a body that represents dentists, and it has a duty to protect its members' interests, which means keeping their costs down, keeping regulation down and keeping bureaucracy down. I understand that. I do not expect a body such as the BDA to say that the legislation is fine, because it has a job to do, and it does it very well. However, we have a duty to the patients. Much of the discussion with the BDA focused on dentists, but we are in the business of protecting patients. This legislation is

needed to protect patients now. There will be other opportunities in the future to consider changes in primary legislation and regulation. I will not pretend that trying to understand regulations is easy. The area is a quagmire. How many times have reform Bills been introduced to try to tidy up regulations? We will be at that it for evermore. There will be other opportunities, but, for now, these regulations will protect patients.

The Chairperson:

I do not know whether George Mitchell is still available. That might be the only way forward. The BDA has had a chance to hear your point of view, but my difficulty is that it is not a question of black or white or right or wrong; it is a question of two rights, on which it is particularly difficult for us to adjudicate. Is there any chance of the two groups getting together one last time before Christmas to determine whether there is any way in which some form of agreement can be reached? It is very difficult for the Department to deliver the regulations in the absence of consent and support from the BDA and its members. Equally, the BDA has to work with the Department. Is it too much to ask for one further set of negotiations at this stage? The Committee simply cannot see any common ground.

Mr Easton:

It is Christmas, after all.

The Chairperson:

The Committee has a couple of weeks before it must make a final decision. Is it too much to ask for one final series of meetings?

Dr Livingstone:

I am more than happy to meet the BDA again, and I am sure that Donncha is, too. I have a responsibility to ensure patients' safety. I, therefore, do not think that we can easily move away from some of the fundamental elements of the regulations. However, I am happy to discuss with the BDA the ways in which we can map a way forward over a longer period. That might allow us to proceed with the regulations and to consider some other measures in the medium term. I am, therefore, more than happy to meet the BDA.

The Chairperson:

In the absence of a problem with the BDA, what timetable had you envisaged?

Dr Livingstone:

We always anticipated a problem with the BDA. We expected to make those regulations in January. Is that correct?

Mr Billy Baird (Department of Health, Social Services and Public Safety):

Yes. It was going in that direction.

The Chairperson:

In that case, there is still time before Christmas?

Dr Livingstone:

It really is important that we make those regulations well before the beginning of the next financial year.

The Chairperson:

I am going to act like Henry Kissinger by suggesting that the two groups meet within the next two weeks and report back to us. You will have the benefit of the transcripts from the evidence sessions on 24 June and 2 December. We have exhausted all questions, and we really are in an invidious position, because we cannot ignore the views of the major professional body. Equally, we cannot ignore the views of the patient. We are, therefore, in a terribly difficult position.

Dr Livingstone:

Would be it satisfactory if we submitted a paper to the Minister and he wrote back to the Committee?

The Chairperson:

Yes. Members of the BDA may, of course, as representatives of the body or as individuals, talk to the Committee, too.

Mr Gardiner:

Or they could write to us.

The Chairperson:

If agreement is reached and white smoke appears, please let us know. I have to say that the BDA is not the most revolutionary of organisations. *[Laughter.]*

Thank you very much, gentlemen. I hope that we will hear news of some progress.

Dr Livingstone:

Thank you, Chairman.