Compliance is everyone's business

Glenys Bridges, an authority on dental practice management, explains why compliance is a burden that needs sharing.

All over the country practice managers are suffering under the strain of compliance. My advice to them is to develop a structure of supporting roles in order to make the compliance role more manageable. This would allow team members to share responsibility for allocated duties. For example, a lead receptionist could play a vital role in the design and delivery of customer-facing administration services. Appointing colleagues to lead roles reinforces their individual professionalism and, importantly, makes services for patients more sustainable.

Lead roles are not new to the dental workplace; several lead roles are already set out in regulations, such as the Infection Control Lead, Safeguarding Lead and Information Governance lead, to name three. The objective of these lead roles is the creation of a 'go to' expert in the team for these important areas of activity. Someone responsible and competent in keeping up-to-date with developments within the allocated area of responsibility, so they can update the practice's policymakers or managers and then oversee the operational observation of any standards set for the team. Practices can create a 'whole team' culture through the introduction of a wide range of lead roles.

The established roles of Infection Control and Safeguarding Lead provide opportunities for team members to extend[1] their contribution to patient care and support the provision of excellent and, most importantly, sustainable patient care. The CQC Key Lines of Enquiry (KLOE)[2] place high importance on building sustainability into all of the services they regulate. By this they mean services should provide a consistent standard of care, irrespective of which team members are present. For example, if the Patient Complaints Lead is not on the premises and a patient makes a complaint, the appointed deputy would instigate prepared responses to address the patient's concerns, in precisely the same way as the appointed Lead would have done.

Meeting regulatory requirements is significantly more challenging for small practices since the requirements are extensive and the available personnel are few. All too often the entire burden of compliance falls on the practice manager, in addition to their other duties. Not only is this exhausting for that person, but the quality and sustainability of care may be compromised when they become overwhelmed by the compliance burden they must carry.

Within large or small teams, graded lead roles provide a structure to ensure the entire team knows how to meet standards of quality and sustainability. When CQC inspectors visit practices, they need to see that each person involved in delivering the service understands the practice's Statement of Purpose and the meaning of quality and sustainability. Allocating responsibility to all team members based upon their knowledge and skills allows a hierarchy to evolve in which team members have a career pathway within the practice.

American author John C Maxwell[3] identified a five-tier leadership hierarchy, which can guide the formation of a Lead Role Structure for dental teams.

Position level. This is entry level: here the person in question might not have any interest in leadership responsibility, but as a person with practical skill is required to take responsibility for low complexity tasks. Within the dental team, this Lead level corresponds with the most basic lead roles, mostly task-based and suitable for team members at the beginning of their dental career, such as testing smoke alarms, stocking leaflets or information sources in the waiting room or monitoring stock levels.

Permissions level. Colleagues recognise that the leader at this level has knowledge and skills they can call on. Within the dental team, this Grade 2 Lead level might be a qualified dental nurse able to take responsibility for duties such as COSHH management, drugs management, water quality, fire marshal duties.

Production level. These leaders drive forward the team's productivity and duties correspond to the role of the practice manager. Within the dental team, this level includes complex, time-consuming duties directly linked to patient safety; they require specialist training to develop policy and provide advice and guidance to colleagues. In some cases, leads might need to liaise with external bodies. These lead roles include Safeguarding Lead, Infection Control Reception Lead and Information Governance Lead. In some cases, leads might need to liaise with external bodies.

People level. Here the focus of leader is to promote teamwork and interdependency. Within a dental team, this **Grade 4 lead** requires the authority to oversee a range of areas within a service. The Registered manager is the most suitable person to take this general manager role, bringing together the work of each appointed lead and ensuring that their inputs align with the practice's objectives. The level 4 lead must develop a reporting structure, whereby leads report activity within their area of responsibility, initially to them and then on to the whole team during staff meetings. It is essential that compliance becomes part of the fabric of the practice and visible to everyone. The Clinical Governance Lead should be at this level.

The Pinnacle level. People at this level have expertise not available at other levels; they may be inspirational and able to influence the work and safety of others. Grade 5 leads might be an external expert called upon to provide information and enable the team to meet complex standards such as a Data Protection Officer or Radiological Advisor.

Delegation and training

Managers and senior leads need to be aware that there is a potential to build an energetic and motivated team through the effective delegation of lead roles. It is also true that ineffective delegation or relegation of duties

can be counterproductive. When appointing leads, a clear description of the role must be agreed, the resources and training needs of the appointee discussed and met. Most essentially, time for the agreed duties must be allocated; this is particularly important where duties are extensive and safety-related.

The developing dental team

Over the first ten years of dental nurse registration (2008-2018), as a result of developments in GDC regulated training for registerable qualifications and extended duties within the Scope of Practice frameworks pathway has opened up for ambitious dental nurses. The opportunity to extend their Scope of Practice and become active in specified areas of patient care is set out in the GDC Publication Scope of Practice.[1] This includes taking x-rays and suture removal. Expanded Scope of Practice and the introduction of verifiable eCPD requirements are shaping the development of dental teams. There has been and will continue to be a significant increase in the levels of knowledge and skills within dental teams, with competent DCPs involved actively involved in patient care. Professionals with this level of training and commitment have a great deal to offer in lead roles to shape the quality, design and delivery of patient care.

In addition to the expansion of clinical roles within dental teams, the Health and Social Care Act 2008 has shaped significant changes in leadership and management of dental services.

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Since April 2010, dental practices in England have been required to register with the Care Quality Commission (CQC) and produce evidence to demonstrate to CQC inspectors that services meet required Total Quality Standards. This involves everyone in complying with regulations and auditing the processes and procedures needed to deliver that quality.

References

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