Surveillance
The law and ethics of recording in dental surgeries
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Experience in the retail sector suggests that high standards of service are paramount to consumers and by extension, to patients. John Lewis department store is a prime example. It came top in the Institute of Customer Service’s (ICS) most recent Customer Satisfaction Index with a score of 90.8. Among the aspects of customer service rated by over 9,000 consumers was professionalism, quality and efficiency, ease of doing business, timeliness, problem solving and complaint handling.

In my experience, good complaints handling and professionalism are universally appreciated qualities. While dental practices do not share many concerns with retail organisations, it is certainly important to focus on managing patient concerns promptly and constructively because the earlier a complaint can be resolved, the more likely your practice is to retain the patient’s loyalty and avoid the complaint being escalated to the Ombudsman, the Dental Complaints Service or even the GDC.

By contrast, it is also worth considering the reputational damage associated with poor complaints handling and its impact on your practice. According to a separate ICS report, 70% of people who have had a bad customer experience with a member of staff say they will warn others not to use that same organisation. A patient who is unhappy with their treatment and dissatisfied with your response may tell their friends, take their grievance to the press or even make a negligence claim if they believe they have experienced harm.

Our complaints feature on page 13 sets out the rules governing complaints procedures in the NHS and private dentistry across the UK. As DDU adviser Alison Large explains, effective complaint handling at the local resolution stage makes it possible to retain the patient’s confidence and keep control of the situation.

Elsewhere in this issue, dento-legal adviser and periodontist Leo Briggs looks at some of the reasons behind the increasing number of claims involving periodontal care and treatment and offers risk management advice. We also consider the tricky issue of cameras and recording in dental practices, and talk to two recently-qualified dentists who have chosen to work outside a general practice setting.

I hope you enjoy reading this issue of the DDU Journal.

Rupert Hoppenbrouwers
Head of the Dental Defence Union

References
2 Customer service hits the bottom line, ICS, 6 December 2013 http://bit.ly/DDUJ02
Surveillance
society

From CCTV to Google Glass, technology now makes it possible to record nearly every aspect of our daily lives. But what about situations when we traditionally expect privacy? DDU adviser, Leo Briggs, examines the law and ethics of recording in dental surgeries.

A life on camera used to be reserved for celebrities, but no longer. There may now be up to 5.9 million CCTV cameras recording public life in Britain, including 750,000 in ‘sensitive locations’ such as schools, hospitals and care homes.

And it isn’t only Big Brother watching us. For anyone who wants to capture the world around them, from ‘life loggers’ to citizen journalists, the camera technology is increasingly accessible, portable and convenient.

The latest innovation is Google Glass, a wearable hands-free camera that is predicted to go on sale in 2014. Medical applications have already been trialled, including live-streaming operations as a teaching aid for medical students.

But the use of cameras in a healthcare setting, including dental practices, is problematic because of the need to protect patients’ confidentiality and preserve the relationship of trust between patients and the dental team. Dental professionals ignore the legal and ethical implications at their peril.
Crimewatch

In most cases, dental practices want to install cameras in public areas, such as waiting rooms, to help prevent or detect crime. However, you do need to be confident that CCTV is necessary and proportionate, so record your reasons and regularly review this decision.

CCTV images of patients are considered sensitive personal data which means you must abide by the Data Protection Act 1998 and follow the relevant national guidance.

The CCTV Code of Practice, published by the Information Commissioner’s Office (ICO) in 2008, contains detailed information on what CCTV operators must do to comply with data protection laws. It explains that CCTV should only be installed for a specific purpose such as crime prevention. You should prominently display signs which clearly warn visitors and staff that surveillance equipment has been installed. Recorded images should not be retained for longer than strictly necessary and should be stored securely.

In June 2013, the government published a new code of practice intended to be used alongside the CCTV Code of Practice. The Surveillance camera code of practice currently applies to local authorities and the police in England and Wales, but other users of surveillance camera systems are encouraged to adopt it voluntarily. Its 12 guiding principles (Section 2.6) are intended to ensure transparency and that appropriate safeguards are in place.

Consent issues

To meet the GDC’s ethical standards, personal information (including images) may only be disclosed without consent to protect patients or the public ‘in exceptional circumstances’. This includes: ‘if a patient puts their own safety or that of others at serious risk, or if information about a patient could be important in preventing or detecting a serious crime’.

If obtaining consent to disclose CCTV images is not practical or appropriate, the GDC advises you to get advice from the DDU or your professional body before releasing it. In general, you are unlikely to be criticised for disclosing footage of a patient committing a crime to the police but you should not need to provide details of their clinical history or the reason for their attendance. Images of anyone unrelated to the incident should be blurred out.

To ensure the CCTV cameras fulfil your intended purpose, seek professional advice about the most appropriate surveillance technology, the location of cameras, facial recognition, time/date stamps etc. Ensure any contract includes guarantees about data security and patient confidentiality.

We also recommend that you ask your practice’s data controller to produce a CCTV policy covering the installation of cameras, the safe storage of images, retention periods and disclosure.
Dental chair-cam

CCTV in public areas is one thing, but recording patient consultations or treatment presents more ethical difficulties because patients are more vulnerable and entitled to expect a greater degree of privacy.

Dental professionals who want to record consultations for teaching or research purposes need to obtain patients’ permission before any recording is made and document this in their clinical record. We also recommend giving patients a further opportunity to consent, and to see the recording afterwards if they wish. Reassure them they can refuse permission or withdraw it at any time without the quality of the care they receive being affected.

Make sure patients understand the purpose of the recording; who will be allowed to see it; how the images will be used; whether copies will be made; the arrangements for secure storage and how long it will be kept. Even if you have a patient’s consent to use their images, it should not usually be necessary to identify them so seek advice on how to anonymise the images.

Some dental professionals have asked us whether they can record consultations to protect their practice against complaints and litigation. We would advise you to be wary of recording consultations solely for defensive reasons as it may undermine your relationship with patients when you seek consent. Recording without permission is not an ethical option.

Any recording you make should be considered part of the patient’s clinical records. This means you can be ordered to disclose it in the event of a complaint, claim or other formal investigation. Patients also have a right to make a subject access request (i.e. ask to see their records) under the Data Protection Act 1998.

The ICO and the Care Quality Commission (COC) expect dental practices to have a consistent approach to subject access requests from patients and their representatives, including your charges for a copy of an electronic record (a maximum of £10). The ICO has recently published a code of practice on this subject but you can also contact the DDU advice line if you have specific concerns.

Not-so-candid camera

The DDU has recently received calls from members who were upset to discover that a patient had surreptitiously recorded their dental appointment. Understandably, they saw it as a sign that their professional relationship with the patient had broken down and wanted to know if they could refuse to treat a patient who recorded them.

In fact, there is no legal barrier to your patients recording their time in the dental chair as they are only processing their own personal information. Section 36 of the Data Protection Act 1998 states: ‘Personal data processed by an individual only for the purposes of that individual’s personal, family or household affairs (including recreational purposes) are exempt from the data protection principles and the provisions of Parts II and III’.

It’s easy to assume the worst if a patient tries to record you at work but it does not always follow that they are trying to catch you out or that a complaint or claim is inevitable. Indeed, a recording could be to your advantage if it helps ensure the patient does not miss anything important. Studies have shown that patients do not always take in what they are told by healthcare workers but if they are able to watch the recording in their own time, it may help them understand the risks and benefits of the different treatment options and make an informed decision about the treatment they want, which makes life easier for them and you.

If you suspect that a patient is covertly recording you, your duty of care means you may not be justified in refusing to treat them. A confrontational response may easily rebound on you and further damage your relationship. A more pragmatic (and potentially disarming) approach would be invite the patient to record the consultation openly and ask them whether you can have a copy of the recording which can then become part of their dental records. In seeking their consent to this you should reassure them that the recording will be stored securely by the practice and only used for this purpose. If you are concerned that the patient’s actions are a sign they do not trust you, you may want to discuss this with them later.

Finally, bear in mind that while recordings (even those made covertly) can be admitted as evidence of wrongdoing by the GDC and in court, they can also prove the opposite. In other words, if you have acted ethically and professionally you should have no reason to be worried.

References
1 One surveillance camera for every 11 people in Britain, says CCTV survey, Daily Telegraph, 10 July 2013 http://bit.ly/DDUJ03
4 Principle 4, Standards for the Dental Team, GDC, September 2013
5 Subject access code of practice, ICO, August 2013
Practical advice and reassurance are just a call away

0800 374 626

Information display

We have invested a lot of money in our new practice website recently but a patient pointed out that our reception noticeboard is in a sorry state, covered with tatty pieces of paper and out-dated information. We have asked our practice manager to put this right but are there any rules about the information we need to display?

It's tempting to assume that your patients can now find any information they need on your practice website but not all your patients will have internet access or the time to look for answers online. So it's just as important to have an up-to-date practice noticeboard. This is in line with the GDC's requirement to communicate effectively with patients and give them the information they need in a way they can understand.

At different points in Standards for the Dental Team (2013), the GDC identifies information that you need to display in an area where it can be easily seen. This includes:

- a simple price list including basic items such as the cost of a consultation, single-surface filling, extraction, different types of radiographs and hygienist appointments
- your complaints procedure
- information about dental team members, including their registration number
- the fact that you are regulated by the GDC, and
- the GDC's nine ethical principles.

It's important to ensure your practice meets these requirements, or you and the other registered dental professionals could be criticised by the GDC.

If your practice provides NHS treatment, the NHS Business Services Authority expects you to also display the latest version of its NHS charges poster (April 2012). These should have been sent to you but further copies can be downloaded from the BSA website at www.nhsbsa.nhs.uk
**Freedom of Information request**

We have been approached by a local journalist who says he is collecting information about the number of patient complaints received by NHS practices in the area over the last three years and what proportion have been resolved. We told him we didn’t want to comment but he has now made a written Freedom of Information request. Do we have to comply?

As an NHS dental practice, you are classed as a public authority and must comply with the Freedom of Information Act 2000 by making certain information available to the general public and responding appropriately to Freedom of Information (FoI) requests.

The journalist’s FoI request is likely to be considered valid as you would already be expected to hold such complaints data. The request is therefore not an unreasonable burden on your resources. Nor could the journalist’s request be refused on the grounds that it is vexatious or that the same person has already made the same FoI request.

It is probably worth clarifying at the outset whether the journalist only wants the headline complaints figures and not details which may identify individual complainants. The practice can legitimately refuse to provide sensitive personal data under the Data Protection Act 1998.

In this case, you would probably be expected to provide the information and will need to comply within 20 working days of receiving the request. (The clock is reset if you need to clarify details with the requester). If you are refusing all or any part of an FoI request, you must send a written refusal notice explaining why. However, you need to be very sure of your ground because the journalist can still ask the ICO to review the request and consider whether your response is appropriate.

If you have not done so already, your practice should have a publication scheme to meet your legal obligations under the Freedom of Information Act 2000. The ICO has produced a model publication scheme for dentists which can be downloaded from its website and sets out the seven classes of information you are expected to provide. You are also expected to produce a guide specifying what information you publish, how it is available and the charge, if any, for access to the information. The ICO says that the model scheme, guide to information and fee schedule should be “available on your website, public notice board, or in any other way you normally communicate with the public”.

**In-house training**

I am an experienced dental hygienist and would now like to extend my existing duties so I can remove sutures for patients after the wound has been checked by a dentist. My practice principal has offered to teach me how to do this in-house but is this appropriate or should I attend an external course?

In principle, it would be fine for you to receive training in-house, providing you can demonstrate that you are trained and competent in this additional skill if called upon to do so.

On its website, the GDC states: “Training can consist of either going on a course or receiving in-house training. However, it is up to you to be sure that you are competent and to be able to demonstrate why you believe that to be the case.” Where training takes place in-house, the GDC says it is important to keep a log of the training “which illustrates your competency if you ever need to justify yourself to the GDC”.

The GDC does not approve individual education providers or courses but offers guidance to practice principals who wish to provide in-house CPD training and it would be prudent to follow this. This means setting out the following in writing:

- concise educational aims and objectives – the activity should have a clear purpose
- clear anticipated outcomes – attendees should know what they can expect to gain as a result of taking part in the activity
- quality controls – attendees should have the chance to give feedback, with a view to improving quality.

You can then retain this course content, along with the log for future reference while your practice can maintain a record of your training in its personnel files.
**Threat to reputation**

A local paper has named my practice in a story about a patient who made serious allegations of poor treatment from her dentist. However, we have never treated the patient and from the description, I think she was treated at another practice in the area with a similar name. This could ruin our reputation - what can we do?

Unfortunately, it is not uncommon for dental professionals to find sensationalist and one-sided stories about them in the local press but it seems this newspaper has not carried out the most basic checks on the accuracy of its story.

As you have no duty of confidentiality to the patient it would be appropriate in this case to contact the newspaper editor and explain that your practice has been wrongly named. You would also be entirely within your rights to ask for the story to be corrected and for a prominent apology to be printed in the next edition.

The DDU’s dedicated press office is always happy to help members who have concerns about media coverage or have been approached by a journalist for comment. A press officer can advise you on your options or contact the editor on your behalf.

Journalists have a professional duty to correct significant inaccuracies as soon as these are recognised and in the DDU’s experience, they are usually willing to do so. However, if you are not satisfied with the editor’s response, you can take your case to the Press Complaints Commission (PCC). The PCC will soon be replaced by a new regulatory system with stronger powers but at the time of writing it continues to investigate complaints which fall within its remit. It can mediate with newspapers to resolve disputes or publish a critical adjudication where it upholds a complaint.

**Non-registrant director**

Last year my partner and I decided to incorporate. One of my oldest friends was recently made redundant and would like to invest in the business. As a condition he wants to join the board of directors and play an active role in decision-making but he is not a registered dentist. Would this be legal?

There is no reason why a non-dentist cannot join the board of a dental body corporate, provided registered dental professionals on the board are at least equal in number to the non-Registrant directors.

Under Section 43 of the Dentists Act 1984, a body corporate is committing an offence if it carries on the business of dentistry at a time when the majority of its directors are not either registered dentists or registered dental care professionals.

If this balance is upset by your friend joining the board, you will need to refuse his request or invite another registered dental professional to join the board.

It’s also important to obtain professional legal and financial advice about accepting investment into the business and the status of new shareholding board members.

“Asking for the story to be corrected and for a prominent apology to be printed in the next edition.”

“It is important to obtain professional, legal and financial advice about accepting investment into the new business.”
Can I ask for the records?

One of my former patients has made a complaint about the treatment I provided which she says has been criticised by her new dentist. I would like to call the dentist to discuss what he has told her and ask if I can see his records. Can I do so?

It’s understandable to want to resolve this problem by speaking directly to your fellow dental professional but it would be a breach of patient confidentiality for you to contact the patient’s new dentist without her consent. The dentist concerned would also be disregarding confidentiality and the Data Protection Act 1998 if he discussed his treatment with you or sent you the patient’s records without her consent.

You could find this approach makes the situation worse if the patient or the other dentist makes a further complaint about your actions. Not only does the GDC expect dental professionals to make sure that their complaints procedure respects patient confidentiality but your response could also be seen as unduly defensive. Standards for the Dental Team (Principle 5) requires you to “deal with complaints in a calm and constructive way and in line with the complaints procedure”, adding that “you should aim to resolve complaints as efficiently, effectively and politely as possible”.

If you need to review the patient’s dental records in order to properly investigate the complaint and provide a constructive response, ask the patient for her written consent to this disclosure, explaining why it is necessary. Alternatively, ask the patient to contact her new dentist directly and arrange for him to send you a copy of her records.

When your practice has completed its investigation, the DDU will be happy to advise on your letter of response to the complaint.

Concerns about a child

A mother has brought her six-year old daughter into the surgery for emergency treatment after she was up all night with toothache. The child’s teeth are in an appalling state and she will need several extractions but she also appeared not to have had a bath in several days and her clothes were very dirty. While her mother seemed very concerned about her daughter, I am worried she is being neglected. Should I report this to social services?

If you are concerned that your patient is suffering from neglect, you must act in her best interests. This means addressing the child’s immediate dental needs and then raising your concerns through the appropriate channels.

It is important to remember that you are not expected to manage the situation on your own and nor is it up to you to find evidence of neglect. If you are unsure whether your concerns are reasonable, seek specialist advice from an experienced colleague such as a fellow dentist, paediatrician, child protection nurse or social worker.

If you then decide to report your concerns, you should make a referral to your local children’s services (formerly social services). This can usually be done over the telephone and followed up in writing within 48 hours but there is likely to be an agreed local process which you should follow. Keep a copy of the referral.

You would generally be expected to talk to the child’s mother about your concerns and explain what you are going to do, unless this would put the child at greater risk. Seek advice from a child protection professional if you are unsure and then make a note in the clinical records of your discussion with the patient’s mother.

The GDC emphasises dental professionals’ ethical responsibilities to safeguard children in Standards for the Dental Team and Guidance on Child Protection and Vulnerable Adults (both 2013). It calls on dental professionals to find out about local procedures for the protection of children and follow them if you suspect that a child might be at risk because of abuse or neglect.

The GDC guidance adds: “If you make a professional judgement and decide not to share your concern with the appropriate authority, you must be able to justify how you came to this decision. You should contact your defence organisation for advice.”

Further detailed guidance and resources on this important subject is available on the website, Child protection and the dental team (www.cpdt.org.uk).

References
1  Guide to Information provided by NHS dentists under the model publication scheme, ICO website http://bit.ly/DDUJ06
Corporate dentistry has been on the rise since the relaxation of restrictions in July 2006. Market analysts Laing and Buisson estimated that £650 million was spent on primary care dentistry provided by UK corporate groups in 2009/10. That is around 11% of total primary care dentistry spending in the UK.

A dental ‘corporate’ is generally a multi-practice group. It may be profit-making or a not-for-profit social enterprise. Increasingly, corporate groups are being established to tender for large NHS dental contracts.

The indemnity situation for multi-practice corporate groups is different from individual privately-owned practices or partnerships. DDU business development manager Noel Waters explained: ‘A patient who thinks they have suffered negligence can take action against the company, rather than – or even as well as – the dental professional who treated them. The owners of multi-practice dental groups may be more remote from day-to-day decision-making in each site but they still have overall responsibility.’

Dental corporates may be held liable for a range of failings, including:
- the poor performance or conduct of individual staff and sub-contractors, particularly employees who do not usually have their own professional indemnity
- inadequate practice systems and procedures such as patient referrals, infection control, and data protection
- poor quality training and lack of regular assessment of staff
- failure to properly investigate complaints or patient safety concerns.

“Corporate groups cannot afford to get bogged down by clinical negligence claims, not to mention the considerable legal expenses they incur, if they are to innovate and take the opportunities available in the rapidly-changing dental market. That is why corporate indemnity is not an option but a necessity,” Noel added.

Corporate membership of the DDU includes:
- indemnity for corporate clinical indemnity claims, including the alleged negligence of employed or contracted staff
- indemnity for legal expenses incurred in relation to an investigation by a government or regulatory body, in defending allegations of corporate manslaughter, harassment or unlawful discrimination
- risk management advice
- access to DDU dento-legal advice and expertise
- an online library of DDU guides, advice articles and case histories.
- a free 24-hour employment law advice line.

For more information, email corporate@theddu.com or call 0800 085 0614

Case study

As this scenario shows, corporate groups are not immune from clinical negligence claims.

A dental nurse and dental associate raise concerns about a senior colleague. They claim the dentist is rude and aggressive and also represents a risk to patients because he ignores the guidelines for making referrals. The corporate group which owns the practice warns the dentist about his conduct but takes no further action.

A few months later a patient with oral cancer makes a claim against the dentist alleging that he failed to make an urgent referral to a specialist. The patient dies shortly afterwards and her family complains about the dentist to the GDC.

During the GDC investigation it emerges that concerns had been raised previously about him. The patient’s family decide to make a claim against the corporate group for failing to properly investigate and act upon earlier concerns.

References
A complaint is never welcome but effective local resolution can retain the patient’s confidence and keep the situation under control. DDU dento-legal adviser Alison Large looks at complaints handling within the practice and explains how an unhappy complainant might take their grievance further.

**Stage 1**  
**Local resolution**

Local resolution, the first stage in any complaints procedure, provides a golden opportunity to resolve a patient’s complaint. Your complaints procedure should be on display in the practice and readily accessible for patients. It should be clearly written, and enable you to investigate grievances efficiently, fairly and consistently. All members of the practice staff should receive training in complaints management, and should know what to do if a patient expresses any dissatisfaction.

Most patient complaints are resolved in-house by the dental professional or the practice complaints manager. If a patient takes their complaint directly to the Ombudsman, they will be redirected to the practice or the primary care organisation to try local resolution first.

The principles of local resolution – professionalism, openness, accountability and respect for confidentiality – are set out in Section 5 of the GDC’s *Standards for the Dental Team* (2013). The DDU can help you respond to complaints, including drafting or checking a written response.

If the patient is still not satisfied despite all your best efforts to resolve the complaint, you should tell them about other avenues that are open to them. For this reason it is better to invite patients to revert to the practice if they are not satisfied by the initial response, rather than straightaway directing them to other avenues. As explained below, these other avenues depend on where you practise in the UK and whether the treatment has been provided under the NHS or privately.

**Stage 2**  
**Independent review**

**NHS treatment**

For NHS patients who are not satisfied with the outcome of local resolution, the second stage involves referral to the appropriate Ombudsman, who can carry out an independent investigation. The process for each country within the UK is set out briefly over the page.
The complaints process is set out in the 2009 document *Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning*. Practices must publish annual reports of complaints and their procedures are subject to inspection by the Regulation and Quality Improvement Authority (RQIA).

Complaints should normally be brought to the practice or local health board within six months. If the patient became aware of a problem later than this, the deadline is either six months from the date of knowledge or 12 months from the incident, whichever is sooner. Health boards also have the authority to act as ‘honest brokers’ by mediating between the complainant and the practice.

Practices must acknowledge complaints within three working days and provide the health board with a copy of the complaint, with the complainant’s consent. Local investigations should normally be completed within 10 working days but if this is not possible, complainants should be told why and when they will receive a response.

Complainants who are not satisfied can take their complaint to the Northern Ireland Commissioner for Complaints (the Ombudsman) which will consider complaints brought within 12 months that meet its criteria (including clinical care and treatment). The Ombudsman aims to complete preliminary investigations within 26 weeks and detailed investigations within 52 weeks. Recommendations can range from an apology to financial redress and the Ombudsman publishes selected case summaries in its annual review.

Arrangements for complaints handling were established under The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and are set out for complainants in the document *Putting Things Right: raising a concern about the NHS from April 2011*. The regulations use the term ‘concern’ which includes both expressions of dissatisfaction from patients and reports of adverse incidents from staff.

Complaints can be made directly to the practice or to the relevant health board within 12 months of an incident, or the patient becoming aware they have a complaint. The complaint should be acknowledged within two working days, investigated and a full response, signed by the responsible officer, sent to the complainant within 30 working days. If it is not possible to complete the investigation within this timescale, complainants should be informed of the reason and told when they can expect to receive a reply.

Patients who are not satisfied can contact the Public Services Ombudsman for Wales (PSOW) which will investigate if the complaint meets its criteria (e.g. there is evidence of systemic failure).

Possible outcomes are that:
- the complaint is not upheld
- the complaint is upheld in full or in part and the provider agrees the proposed remedy (a section 21 letter), or
- the complaint is upheld in full or in part and the provider has not indicated that it will accept the recommendations or it is in the public interest to publish a report (a section 16 report).

The PSOW may recommend practices give an apology or explanation, review their procedures or reimburse complainants’ costs, although it has no powers to enforce recommendations or impose sanctions.
The right to give feedback and complain is central to the Patient Rights (Scotland) Act 2011. The Act also requires healthcare providers to monitor and learn from the feedback and complaints that they receive. The process is set out in The National Health Service (General Dental Services) (Scotland) Regulations 2010.

Complaints can be made either directly to the practice or to the relevant health board within six months of an incident, or the patient becoming aware they have a complaint if this is not later than 12 months after the event. A full response is required within 20 working days; otherwise the complainant should be told when they can expect one.

Patients can take unresolved complaints to the Scottish Public Services Ombudsman (SPSO). This is not an appeal body but can look at the way the complaint was managed, providing it is informed within one year.

Following an investigation, the SPSO will produce a decision letter or an investigation report (if it is in the public interest to do so) which is sent to the Scottish Parliament and ministers. The SPSO might recommend a practice to apologise or give an explanation, review their procedures, reimburse costs or make other suitable redress. It may ask the organisation to provide evidence that these have been carried out.

Dentists can request a review of SPSO decisions in limited circumstances although not solely on the grounds they disagree. Speak to a DDU adviser if you are unsure.

The NHS and Social Care Complaints Procedure was established under the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. Local practice complaints procedures are subject to inspection by the Care Quality Commission.

Complaints under local resolution can be made to the dental practice or to the relevant commissioning body (NHS England) within 12 months of the date on which the concern arose, or from when the complainant first knew about it. Complaints (other than oral complaints resolved in 24 hours) should be acknowledged in three working days, and the complainant informed when they can expect a formal response.

Dissatisfied complainants can take their case to the Parliamentary and Health Service Ombudsman (the Ombudsman) within 12 months. If it decides to investigate, the Ombudsman will review documents, interview both parties and obtain expert opinion if necessary. It will then prepare a confidential draft report for the complainant and dental professional to check for accuracy before a final report is sent to all interested parties. Note that an anonymised copy may be published on the Ombudsman’s website.

If the practice or an individual dental professional is found to be at fault, the Ombudsman may recommend changes to working practices, and sometimes financial redress for the complainant. Although compliance with recommendations cannot be enforced, most practices usually choose to comply. In the past, the Ombudsman has publicly criticised organisations for failing to co-operate with an investigation or ignoring its recommendations.
**Private treatment**

When a complaint about private treatment cannot be resolved locally, patients throughout the UK can take their case to the Dental Complaints Service (DCS).

Established in 2006, the DCS is funded by the General Dental Council (GDC) but acts independently of it. The free service looks into private complaints that are raised within 12 months of treatment or 12 months of the patient becoming aware of a problem.

DCS advisers prioritise informal resolution which involves working with the complainant and the dental professional to try and reach agreement. If this proves impossible, complaints can be referred to a panel of volunteers (two lay and one professional). The panel will hear from both parties at a meeting and if agreement still cannot be reached, it will make one or more of the following recommendations:

- a partial refund
- a full refund
- a full refund plus a contribution towards remedial treatment, up to the cost of the original treatment
- an apology
- no further action
- that the dental professional reviews their current practices.

The DCS has no formal enforcement powers and there is no appeals process. However, it can refer a dental professional who fails to co-operate with it to the GDC on the grounds they have not met the GDC’s requirement to deal with complaints properly and professionally.

**Escalating grievances**

Bear in mind that a complainant who is unhappy with your response may decide to complain directly to the GDC which will investigate if the matter raises questions about the dental professional’s fitness to practise. Or they can make a negligence claim if they can show that they suffered avoidable harm because the dental professional owed them a duty of care and acted negligently.

Increasingly, patients also have the option of sharing their experience of dental practices on websites such as NHS Choices and the Care Quality Commission (CQC) in England. The CQC promises to use patient feedback to help it monitor services and decide when to inspect providers.

**Ombudsman websites:**

- Parliamentary and Health Service Ombudsman (England)  
  www.ombudsman.org.uk
- Scottish Public Services Ombudsman (SPSO)  
  www.spso.org.uk
- SPSO Complaints Standards Authority  
  www.valuingcomplaints.org.uk
- Public Services Ombudsman for Wales  
  www.ombudsman-wales.org.uk
- Northern Ireland Ombudsman  
  www.ni-ombudsman.org.uk

**Local resolution – top tips**

1. Ensure patients and staff are aware of your practice complaints procedure.
2. Provide regular training on complaint resolution to all patient-facing staff.
3. Acknowledge complaints promptly.
4. Be professional and fair at all times.
5. Clarify what the complainant wants and address their concerns.
6. Direct them to independent advice such as the Patient Advice Liaison Service (PALS) and Citizens Advice.
7. Provide a written response within the time limits set out in your local procedure.
8. Explain what happened and apologise if errors have been made or the patient has been inconvenienced or upset.
9. Be ready to make changes to your practice in the light of investigation findings and be open and honest with the complainant about these.
10. If appropriate, offer a goodwill gesture such as a refund.
11. Seek advice from the DDU about your written response and contact us straight away if there is a possibility that the patient will make a claim.

**References**

2. Complaints in health and social care: standards and guidelines for resolution and learning, Department of Health, Social Services and Public Safety, 1 April 2009  
DDU welcomes Dr Eric Whaites

Dr Eric Whaites, consultant dental radiologist, has joined the DDU’s Dental Advisory Committee and the MDU Council, where he will provide expert input on issues affecting the whole dental membership. Dr Whaites is senior lecturer/honorary consultant and head of the dental radiological imaging department at King’s College London Dental Institute, where he has been for 30 years. He is a former president of the British Society of Dental and Maxillo-Facial Radiology and the European Academy of Dental and Maxillo-Facial Radiology.

BDA Conference

John Makin, DDU dento-legal adviser, will be a keynote plenary speaker at this year’s BDA Conference and Exhibition (10-12 April at Manchester Central Convention Complex). He will be talking about Complaints – a tactical team approach, examining the role of the whole dental team in meeting patients’ increasingly demanding expectations of good customer service.

Join us at the BDA Conference and Exhibition 2014. We’re at Stand 12A.

Farewell to Mark Phillips

In March, Mark Phillips, one of our longer-serving dento-legal advisers, retired. Mark joined the DDU in 1997 and in his time with us has provided expert advice and assistance to thousands of members who found themselves in difficulties. His many letters of thanks are a testament to the depth and breadth of his experience.

Mark joined the DDU from general dental practice, and for many years has also taught clinical skills in the Prosthetics Department at Kings College London Dental Institute. He will continue in that role, and we are happy to say that he will also continue working for the DDU as an independent consultant on a part-time basis.

Rupert Hoppenbrouwers, head of the DDU, said: ‘We wish Mark well in his retirement. He has been an immensely valuable and highly valued colleague. He has supported large numbers of members over the years, and his hallmark has been his empathy for members who find themselves in difficulty. Members will continue to benefit from his huge experience when he returns to help staff the DDU’s helpline, after a well deserved break’.

Online ethics hit

Our online ethics module is proving a big hit with members. So far, more than 700 members have extended their knowledge of difficult ethical situations and over 500 have gained the verifiable CPD certificate. Members say they find it challenging but very useful.

If you haven’t sampled the course yet, you can find it at theddu.com/learn.

CORRECTION – Patient Group Directions (PGDs)

We would like to alert members to revisions to our online guidance on Patient Group Directions (PGD). We became aware of an error in the previous advice regarding the need for pharmacists to sign a PGD. The Human Medicines Regulations 2012 require that a PGD must be signed by a dentist and a pharmacist. We apologise to any members who may have relied on incorrect advice.

The revised guidance can be accessed at theddu.com. Search for Patient Group Directions.

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Periodontal disease is widespread and as much a threat to patients’ oral health as tooth decay but the DDU continues to receive claims alleging failure to diagnose or treat the condition properly. Periodontist and DDU dento-legal adviser Leo Briggs analyses the latest statistics and provides risk management advice.
Around 45% of the adult dentate population in England, Wales and Northern Ireland have periodontal pocketing exceeding 4mm and just under 10% have advanced periodontal disease which can eventually lead to tooth loss.

Dental professionals have a critical role in monitoring their patients’ gum health at each check-up, and in diagnosing periodontal disease and advising those who are at risk. In the minority of cases where this does not happen, the dental professional is increasingly vulnerable to a negligence claim and even a GDC investigation.

We analysed the reasons for, and outcome of, 170 claims involving periodontal disease that were closed between 2008 and 2012. Of these, we settled 126 (74%) on behalf of members and paid out over £2.8m in compensation and a similar amount in legal fees. In 25 cases, the dental professional also faced a formal complaint and in five cases, their fitness to practise was investigated by the GDC. The remaining 44 claims were discontinued by the claimant.

The number of settled claims rose from 21 in 2008 to 30 in 2012, reflecting the increase in claims overall during this period. However, there has also been a rise of nearly 50% in the average compensation payout each year, from £21,425 in 2008 to £31,607 in 2012.

The largest damages award was £170,000 for failure to diagnose and treat periodontal disease leading to bone and tooth loss. In this case, in addition to general damages for pain, suffering and special damages to pay for remedial treatment, the patient was also entitled to significant compensation for their loss of earnings as they were unable to pursue their chosen career.

**Allegations**

The most common primary reasons for the 126 settled periodontal claims were as follows:

- **Failure to diagnose and treat periodontal disease**: 94 claims (75%)
- **Poor management of periodontal disease**: 14 claims (10%)
- **Communication**: 6 claims (5%)
- **Other**: 12 claims (10%)

**TOTAL**: 126

Thirty two settled claims featured more than one allegation, such as failure to diagnose periodontal disease, failure to diagnose caries and an unsatisfactory bridge.
**Failure to diagnose and treat periodontal disease**

This was by far the most common allegation to feature in our analysis, representing three-quarters of settled claims. The average compensation awarded in these cases was £25,600, slightly higher than for other claims.

Such claims are especially difficult to defend if there is no indication in the records that the dentist has carried out a periodontal assessment during examinations. Many of the patients reported bone and tooth loss as a result of undiagnosed periodontal disease and the subsequent failure of costly dental work such as implants and crowns. Their compensation would have covered this, as well as the ongoing cost of treatment to stabilise their condition, such as additional visits to the hygienist and specialist periodontal treatment.

**Poor management**

In 14 cases, periodontal disease was diagnosed but the dental professional was accused of not managing the condition properly or failing to make a suitable referral, sometimes over several years. Often, the patients only discovered there was a serious problem when they changed dentist. This left the dental professionals involved open to an allegation of supervised neglect, particularly if they failed to record a treatment plan, any discussions with the patient about the advice given and their ongoing monitoring of the patient’s condition.

**Communication**

A small number of cases reflected a breakdown in communication between dentist and patient. Most allegations centred on whether the periodontal treatment provided had been ‘unnecessary’, implying that the patient believed they had not been fully informed about the treatment, its risks, benefits and possible alternatives, and had therefore not given proper consent.

**Risk management advice**

Incomplete or inaccurate records were a common theme in settled periodontal claims. In some cases, this simply made it more difficult for the dental professionals concerned to monitor the patient’s progress and meant they could not appreciate a marked deterioration. However, failure to record relevant details of the treatment plan and the advice given would also make it significantly more difficult to challenge the patient’s version of events.

The DDU offers the following risk management advice to help dental professionals reduce the risk of a successful claim relating to periodontal disease.

- Follow available national guidance to ensure your treatment plan is evidence-based, e.g. the British Society of Periodontology’s guidance on the Basic Periodontal Examination (BPE) is recommended by the Faculty of Dental Surgery.
- Record all your examination findings in the patient’s clinical notes, including their BPE scores and your assessment of their periodontal health. Make a note of factors such as the presence of plaque, calculus and gingival bleeding that may make them susceptible to periodontitis and in need of closer examination at future appointments.
- Explain to the patient if they are at risk of periodontal disease and how they can protect themselves, e.g. information about the link between diabetes and periodontitis, the need for good oral hygiene and more frequent visits to the hygienist, the importance of smoking cessation etc. Make a note of the conversation.
- If you decide that the patient’s gum disease only requires monitoring and advice at this stage, you should still explain this to them and record your discussion and their consent to your treatment plan in the records. Ensure you have a system in place to record periodontal pocketing and loss of attachment at each visit.
- When obtaining consent for periodontal treatment, take time to explain the risks, benefits and alternatives. Make a careful note of what you discussed and their agreement in the clinical records.
- If the patient fails to respond to treatment, including a failure to carry out adequate plaque control despite repeated oral hygiene instruction, make a note of this in the records, along with the explanations given to the patient regarding the consequences.
- Recognise the limits of your own clinical skills. Be prepared to offer referral to a specialist if the patient’s condition does not improve despite treatment.

**References**

1. Disease and related disorders – a report from the Adult Dental Health Survey 2009, The Health and Social Care Information Centre, 24 March 2011
2. Basic Periodontal Examination, British Society of Periodontology, October 2011
The world of general practice has a strong pull for students. After five years at dental school, newly-qualified dentists have a chance to put their skills and knowledge to the test and experience the camaraderie of working in a dental team. The first few weeks may be tough but many quickly settle into the rhythm of life in primary care dentistry and enter an established dental practice as an associate at the end of the year.

But Sharan Nathan and Yasmin Allen chose a different path last year. They shared a split training post with Virgin Care, based in Surrey, dividing their working week between three days’ practising Special Care Dentistry and the remaining two days within dental public health. For them, this represents the best of both worlds: honing their clinical skills while learning about the factors influencing the population’s dental health, an aspect of dentistry that was not covered in depth during their student years.

Before joining Sharan, Yasmin worked for a year as a dental SHO in Liverpool, a post she successfully applied for soon after qualifying and before even beginning her foundation training. She remembers intense competition for the limited number of places available but believes the experience was worth it because of the opportunity to develop her skills under expert supervision.

She explains: “Working in a hospital setting allowed me to experience the different dental specialties such as oral surgery, oral medicine, restorative dentistry and Special Care Dentistry. I enjoyed the challenge of examining a wide range of pathologies and then reporting to my consultant, deciding what diagnostic tests were required and developing an appropriate treatment plan. And of course, in witnessing the referral process from the other side, I can now appreciate what information referring practitioners should include.”

Yasmin’s colleague, Sharan Nathan applied for a dental core training post directly after her DF1 training year. She says: “I certainly enjoyed my DF1 experience but I just knew my next step wasn’t to remain as a GDP. I was determined to continue with postgraduate training. I often felt quite limited in the practice environment and felt a real need to enhance my skills. Being a young graduate, I felt it was easier to continue down a learning pathway. Personally, I found it easier to learn new things and apply them, which I think many new graduates can relate to.

“I searched via the London and KSS deaneries before I saw this post advertised on the NHS Jobs website and applied. The process was quite testing but at the end of the day, the interview panel wants to be convinced that you are committed and curious about the specialty concerned, even if you don’t have direct experience.”

As part of the community dental service, Sharan and Yasmin worked in clinics and domiciliary settings, often encountering patients with challenging dental health problems. Sharan observes: “Special Care Dentistry often requires us to do quite a lot of groundwork with the patient’s family after they have been referred by their dentist. For instance, many are quite angry that their child’s problems
have not been addressed earlier or want to know why they can’t be treated by their own dentist. Without a doubt the cases we came across were very challenging but this certainly should not put anyone off. We dealt with a lot of children with dental decay who needed treatment under sedation or GA. We also treated phobic adults and patients with special needs. The skills you learn are transferrable across all domains within dentistry.”

Sharan and Yasmin believe the public health component of their role complements the special care work they do, helping them understand the wider social determinants of health, such as deprivation and access to dental treatment, something they expect will be even more important when the new dental contract is introduced. Based within the primary care trusts and then the local authority, they have integrated within new teams and learnt new skills as a result.

Working within the local dental team, they have undertaken a number of assignments, such as preparing the local service for the introduction of the NHS 111 helpline; helping develop a new patient initiative for local practices; and carrying out a root cause analysis of ‘wrong site’ adverse incidents. The latter required them to present their findings to colleagues in the Community Dental Service – a nerve-racking but rewarding experience recalls Sharan, and a great addition to their CV.

“**I’d encourage any newly-qualified dentist to test themselves outside a general practice setting as it brings opportunities you might not get later in your career.”**

They say these are things they would never have had the opportunity to do had they not taken up this training post. It has also allowed them to meet many influential dental colleagues and network across the region.

After a year in post, both dentists are now enthusiastic advocates of core training. “I’d encourage any newly-qualified dentist to test themselves outside a general practice setting as it brings opportunities you might not get later in your career,” advises Sharan. “The experience of working with consultant specialists has increased my confidence about taking on more complex cases and we have made some great contacts.”

Yasmin adds: “Go for it while you can! Bear in mind that incomes in general practice are generally higher so it is harder to leave once you have been there for a few years. But there are few better opportunities to experience dentistry outside a general practice setting.”

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**Note**

Dental core training (DCT) posts replaced DF2, Dental SHO and Dental Career Development Posts in 2013.