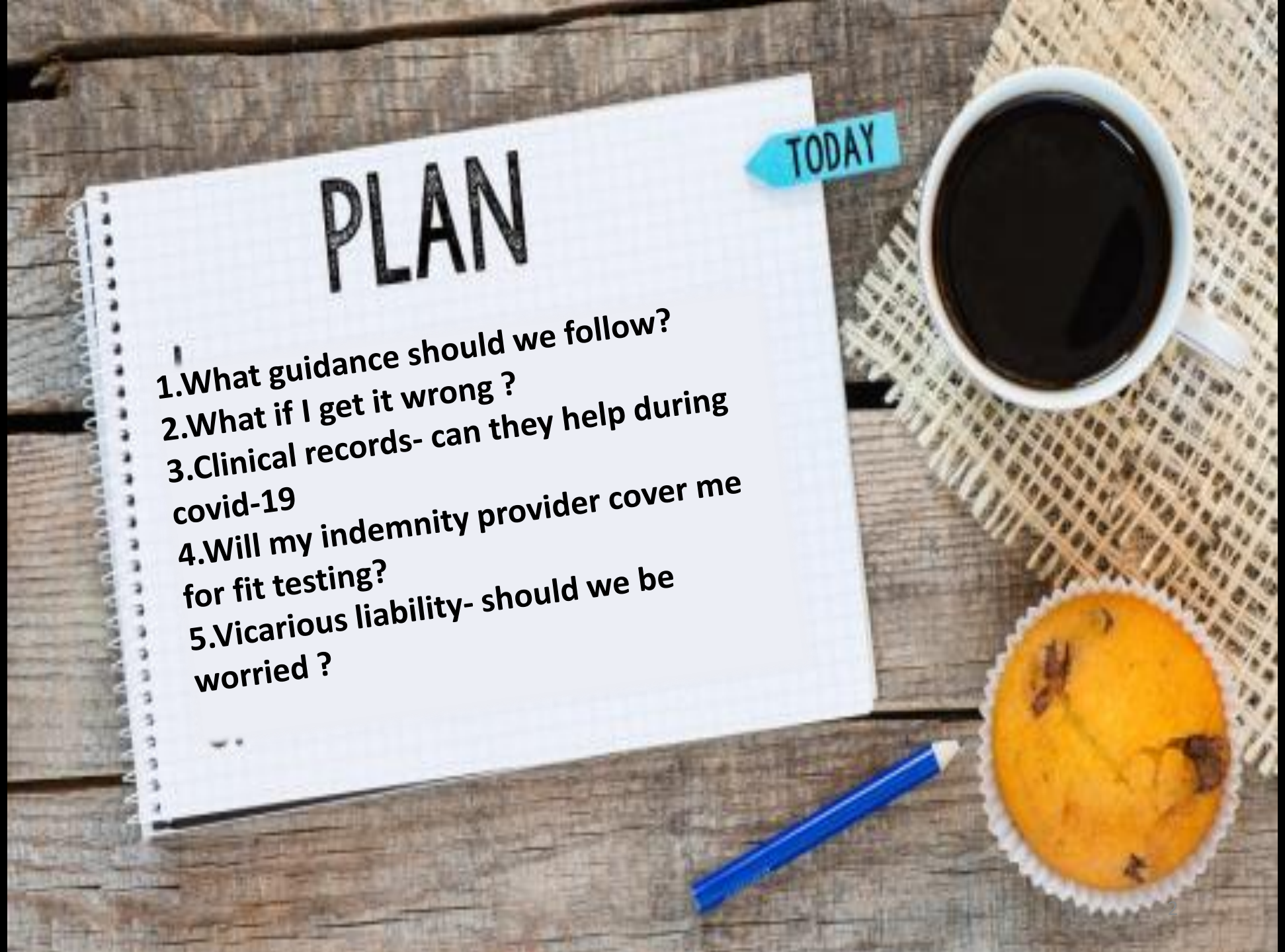
ANNUAL CONFERENCE OF LDC Local Dental Committees

BDA British Dental Association Indemnity

Confused…?

Len D’Cruz

Head of BDA Indemnity



1. What guidance should we follow?
2. What if I get it wrong ?
3. Clinical records- can they help during covid-19
4. Will my indemnity provider cover me for fit testing?
5. Vicarious liability- should we be worried ?

June 8th return announced on Thursday 28 May

ensure safe care for patients and staff.

06:18 Fri 29 May

THE TIMES
Friday May 29 2020

News | Coronavirus

Thousands given a date with dentistry

ontinued to perform geries wearing full PPE TTY IMAGES

bons

in sight for the ds of patients have suffered pain in the pan- with the govern- authorising the ening of NHS and ate dental practices n June 8.

ll non-emergency appointments were cancelled on March 25 to reduce the spread of the coronavirus and high street practices were shut overnight.

Patients in need of urgent dental care have been treated at emergency NHS hubs but the arrangement has drawn criticism owing to restrictive criteria as to what counts as an emergency. About 550 units across the urgent dental care network have been treating patients from more than 9,000 closed practices.

Some patients cla to have resorted drastic DIY home tractions using p others who did meet the criteri

Matt Hancock @MattHancock · 19h

m very pleased we can start to reopen dentists om 8 June.

nk you to @TheBDA & all those who have ked so hard to achieve this.

eet your reply

20

2

What guidance do I follow?

NHS Education for Scotland

Scottish Dental Clinical Effectiveness Programme

Resuming Ge
Following C
A guide and in
for genera
For Phase 2
remo
25

This advice might change as new information
using the most recent version of this documen

NHS

Classification: Official

Publications approval reference: 001559

To: Dental practices
Cc: Regional dental commissioning leads

28 May 2020

Dear colleagues

RESUMPTION OF DENTAL SERVICES IN EN

Thank you for your contribution through the pe
commitment to supporting the national respor

On 25 March 2020 we wrote to NHS dental
services due to the overriding need to limit t

- deferring routine, non-urgent dental
- establishing remote urgent care ser
urgent needs and
- setting up networks of urgent denta
clinically necessary.

We are incredibly grateful to the clinician
challenge in providing remote services a
care sites from existing practices, acute
patients' urgent dental care needs.

This letter now sets out next steps for
NHS moves into the second phase of

Implications of
management of
A pra

College of Ger
Dentistry

OCDO
OFFICE OF CHIEF DENTAL OFFICER ENGLAND

NHS

Standard operating procedure
Transition to recovery

A phased transition
for dental practices
towards the resumption
of the full range of dental provision

Published 4 June 2020: Version 1

BDA
British Dental Association

Our priority has and will be the safety of you, your team and your patients, and the financial sustainability of your practice.

BDA
British Dental Association

COVID-19 special guidance

RETURNING TO ROUTINE CARE

This toolkit is designed to help practices return to safe clinical practice.

It uses a number of different sources from both this country and abroad. It will be updated as new guidance and evidence becomes available.

Please make sure you are using the most up-to-date version. Members will be notified when updates are made.

Our priority has and will be the safety of you, your team and your patients, and the financial sustainability of your practice.

BDA
British Dental Association

COVID-19 special guidance
Version 4 | Thursday 18 June 2020

RETURNING TO FACE-TO-FACE CARE

ENGLAND

This toolkit is designed to help practices return to safe clinical practise.

It uses a number of different sources from both this country and abroad. It will be updated as new guidance and evidence becomes available.

Please make sure you are using the most up-to-date version. Members will be notified when updates are made.

Our priority has been and will be the safety of you, your team and your patients, and the financial sustainability of your practice.

A comparison of UK return-to-practice guidance and standard operating procedure documents

19 June 2020

Gavin Wilson, Manas Dave, Thibault Colloc and Derek Richards

In recent weeks, a number of key return-to-practice guidance and standard operating procedure documents have been produced for the various countries of the UK (England, Northern Ireland, Scotland and Wales) as well as by two UK-wide organisations, the BDA and the FGDP(UK)/CGDent. This comparison of the six main documents was developed following a request from SDCEP. It has been produced with the agreement and involvement of the source organisations and has already informed subsequent updates of these resources.

However, these are not the only documents that are available, with additional resources being provided by, for example, the British Endodontic Society, British Orthodontic Society, British Periodontal Society, Faculty of Dental Surgeons, Royal College of Surgeons of England and the Oral Health Foundation.

While the six main documents may appear to be different, their content is remarkably similar.

What guidance do I follow?

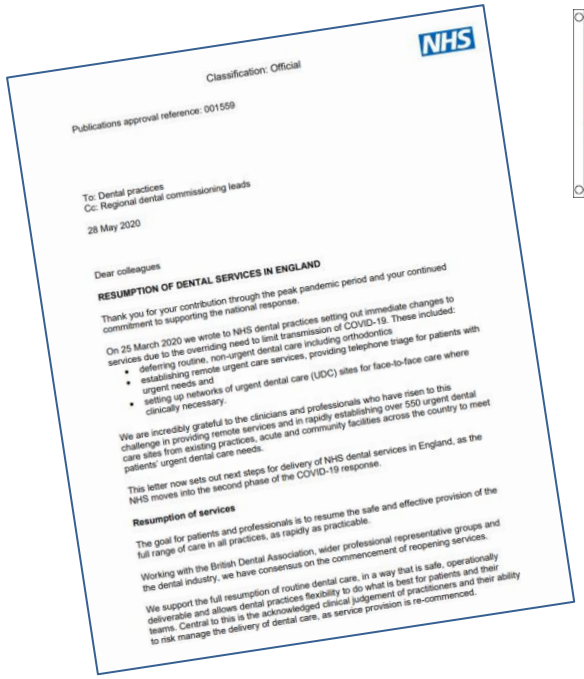
Start with the OCDO guide if you have an NHS contract

- You will be expected by CQC/GDC and any lawyer to follow national guidance
- Apply and adapt it to your practice taking into account your particular practice circumstances
- Have a Standard Operating Procedure (SOP)

WDC STANDARD OPERATING PROCEDURE | v1 03.06.20

Guidance

Am I allowed to see “routine patients” and do check-ups?



NHS

Classification: Official

Publications approval reference: 001559

To: Dental practices
Cc: Regional dental commissioning leads

28 May 2020

Dear colleagues

RESUMPTION OF DENTAL SERVICES IN ENGLAND

Thank you for your contribution through the peak pandemic period and your continued commitment to supporting the national response.

On 25 March 2020 we wrote to NHS dental practices setting out immediate changes to services due to the overriding need to limit transmission of COVID-19. These included:

- deferring routine, non-urgent dental care including orthodontics
- establishing remote urgent care services, providing telephone triage for patients with urgent needs and
- setting up networks of urgent dental care (UDC) sites for face-to-face care where clinically necessary.

We are incredibly grateful to the clinicians and professionals who have risen to this challenge in providing remote services and in rapidly establishing over 550 urgent dental care sites from existing practices, acute and community facilities across the country to meet patients' urgent dental care needs.

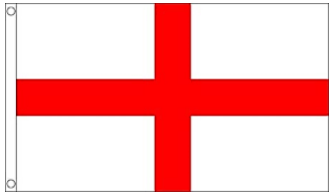
This letter now sets out next steps for delivery of NHS dental services in England, as the NHS moves into the second phase of the COVID-19 response.

Resumption of services

The goal for patients and professionals is to resume the safe and effective provision of the full range of care in all practices, as rapidly as practicable.

Working with the British Dental Association, wider professional representative groups and the dental industry, we have consensus on the commencement of reopening services.

We support the full resumption of routine dental care, in a way that is safe, operationally deliverable and allows dental practices flexibility to do what is best for patients and their teams. Central to this is the acknowledged clinical judgement of practitioners and their ability to risk manage the delivery of dental care, as service provision is re-commenced.



Publications approval reference: 001559

28 May 2020

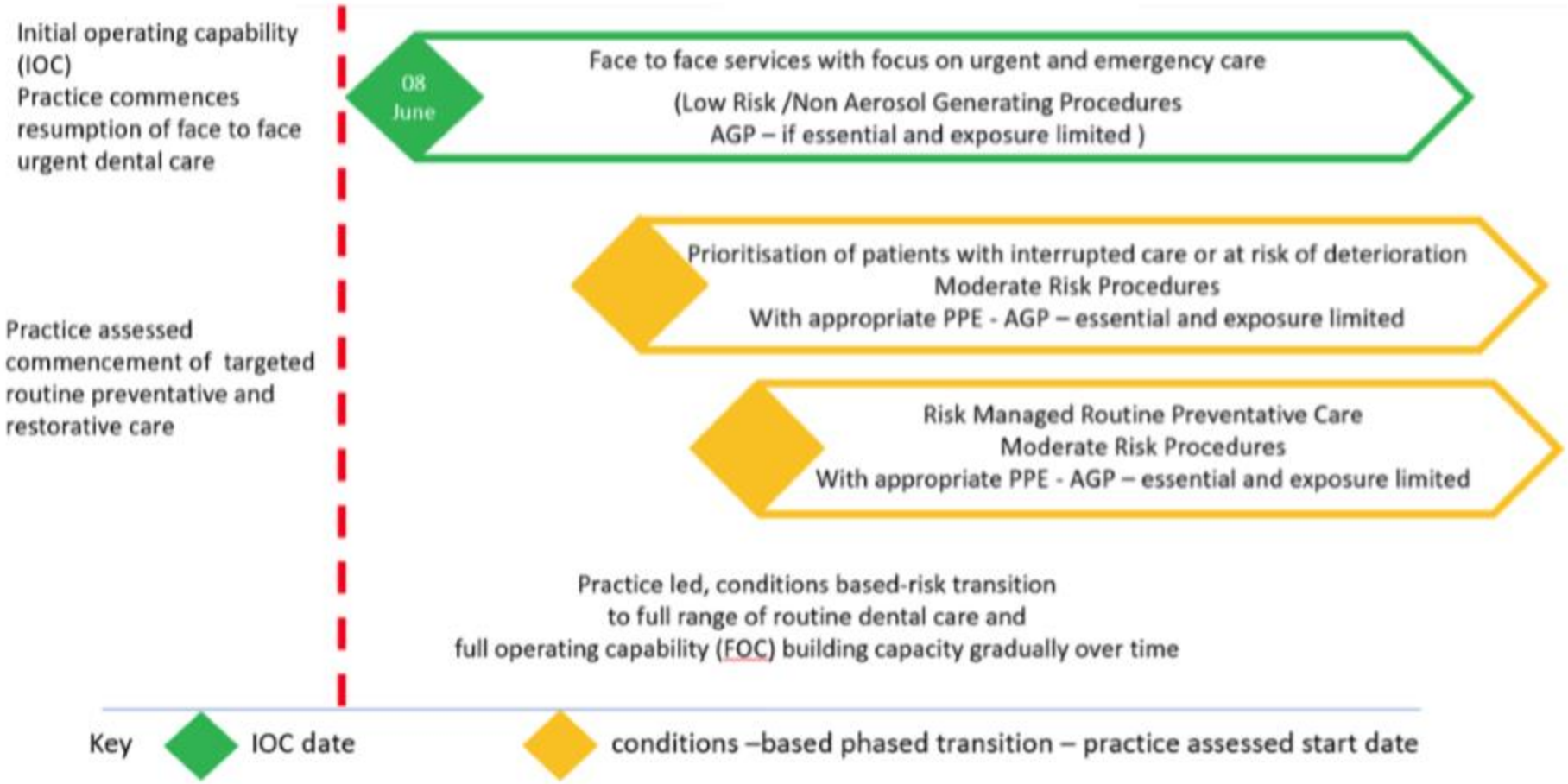
We support the full resumption of routine dental care, in a way that is safe, operationally deliverable and allows dental practices flexibility to do what is best for patients and their teams.

Central to this is the acknowledged clinical judgement of practitioners and their ability to risk manage the delivery of dental care, as service provision is re-commenced.

Our advice is that the sequencing and scheduling of patients for treatment as services resume should take into account:

- the urgency of needs
- the particular unmet needs of vulnerable groups
- available capacity to undertake activity

Progression to resumption of the full range of routine dental care will be risk-managed by the individual practice and can include aerosol-generating procedures (AGPs), subject to following the necessary IPC and PPE requirements.


Initial operating capability (IOC)
Practice commences resumption of face to face urgent dental care
08 June
Face to face services with focus on urgent and emergency care
(Low Risk /Non Aerosol Generating Procedures
AGP – if essential and exposure limited)
Prioritisation of patients with interrupted care or at risk of deterioration
Moderate Risk Procedures
With appropriate PPE - AGP – essential and exposure limited
Practice assessed commencement of targeted routine preventative and restorative care
Risk Managed Routine Preventative Care
Moderate Risk Procedures
With appropriate PPE - AGP – essential and exposure limited
Practice led, conditions based-risk transition
to full range of routine dental care and
full operating capability (FOC) building capacity gradually over time
Key
IOC date
conditions –based phased transition – practice assessed start date

Scottish Government
Riaghaltas na h-Alba
gov.scot

Population Health Directorate
Chief Dental Officer & Dentistry Division

E: NHSgeneraldentalservicesmailbox@gov.scot

20 May 2020

Remobilisation of NHS Dental Services in Scotland

Dear Colleague,

My purpose in writing to you is to explain the first steps for the remobilisation of NHS dental services in Scotland.

As you will be aware this is an extremely complex process. We need to be mindful of the oral health needs of patients balanced against the wider situation with COVID-19, and the essential requirement that we reduce the risk of community transmission and protect both patients and dental teams. We need to take into consideration the added risk of aerosol generating procedures on COVID-19 transmission; the availability of appropriate PPE is also a major consideration in how we shape the recovery and remobilise NHS dental services.

In summary these are the key phases of remobilisation that we have identified at present:

20 May 2020

Phase One
Dental practices closed to face to face consultation
Expansion of the Urgent Dental Care centres

Phase 2 Restarting dental practices

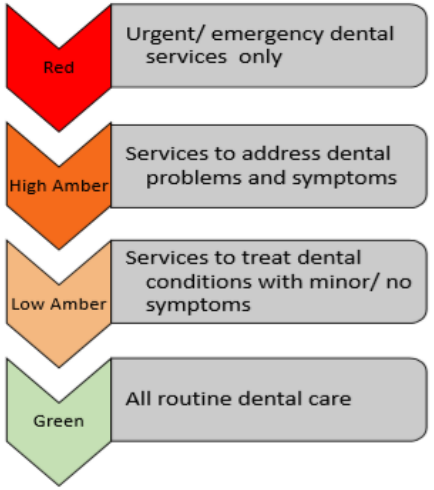
2a) Face to face consultations for non AGP urgent care
2b) Face to face expanded to cover routine care , including examinations but only non AGP treatments (after July31)

Phase 3 Introducing AGPs
Limited introduction of AGPs to dental practice dependent on evidence of risk and possible mitigation

Table 1					
Covid-19 Dentistry	**Now Mar- June 20**	**Phase 1 July–Sept 20**	**Phase 2 Oct-Dec 20**	**Phase 3 Jan 21-Mar 21**	**Future Considerations**
Response	AMBER alert 17/03 & RED alert of pandemic plan 23/03 CDO letters No routine dental care Dental practices open for telephone contact and F2F assessment & urgent care no AGPs 15 UDCs established Emergency/urgent care AGPs in necessary	De-escalation, RED alert phase to heightened AMBER of pandemic plan in dentistry Continuation & strengthening of UDCs for urgent needs & AGPs definitive treatment need extend to practices Patients re-assessed in practices they normally attend, dental care and preventive interventions that do not involve an AGP	Address backlog of need Include people who attend dentistry routinely. Provision of definitive care for UDCs patients & those contacting dental practices since 23/03 with dental problems and/or pain or swelling who have on-going treatment need, include those not meeting strict criteria for urgent care who have treatment need delayed, postponed or self-managed.	Reinstate routine assessment and care. Use the opportunity to take lessons learnt from dental contract reform to inform the way of working and embed that NHS dentistry delivery	UG & PG issues DFT & DCT considerations
Purpose of Stage	Reduce community transmission Covid-19 Stop AGPs in practices Reduce travel and maintain social distancing protect staff and patients	Easement of lock down Resumption of dental care provision Consideration of orthodontic provision	Continuity and recovery	Return to 'new' normal	PPE supply in all stages
Practices	Maintain telephone contact with patients collaborate with other practices standard PPE Report weekly to eRMS Volunteer to UDCs or wider NHS effort, no redundancies Ensure NHS staff receive average net income Prepare for restoration	Buddy CR practices with new practices to programme Ensure all have received training and ACORN guidance packs ACV restored	Resume AGPs in practices that are part of UDC network	**Review ACORN % completion** **Numbers of patients attending**	
Health Boards	Monitor UDCs & practice returns, monitor adherence to CDO directions including finance prepare restoration	ACV restoration and UDAS calculation Include practices in UDC network	**Attend anywhere implementation**	**KPIs & access** **ACORN completion** **delivery**	
CR Team & Dental branch	Redeployed to Covid-19 response. In May and June need some staff to support implementation of restoration plan and mentor practices Introduction of guides and online learning etc.	Support communications Support once for Wales calculations of UDAS & ACV proportional to performance and recruitment/service delivery to march 2020	**Continue to support CR implementation all practices** **Analysis of OHNA & KPIs**	**Work on costed pathways**	
Other planning considerations	Secondary care USCs Orthodontics DFTs DCTs UGs & PGs HIW & HEIW & BDA liaison	Strengthen CR team £ & contract reform Attend Anywhere in dentistry Consultation on future changes to patient charges	**Prepare for PCR change proposal and consultation**	Prepare regulatory change	

Llywodraeth Cymru
Welsh Government

De-Escalation Alert Levels and Dental Services

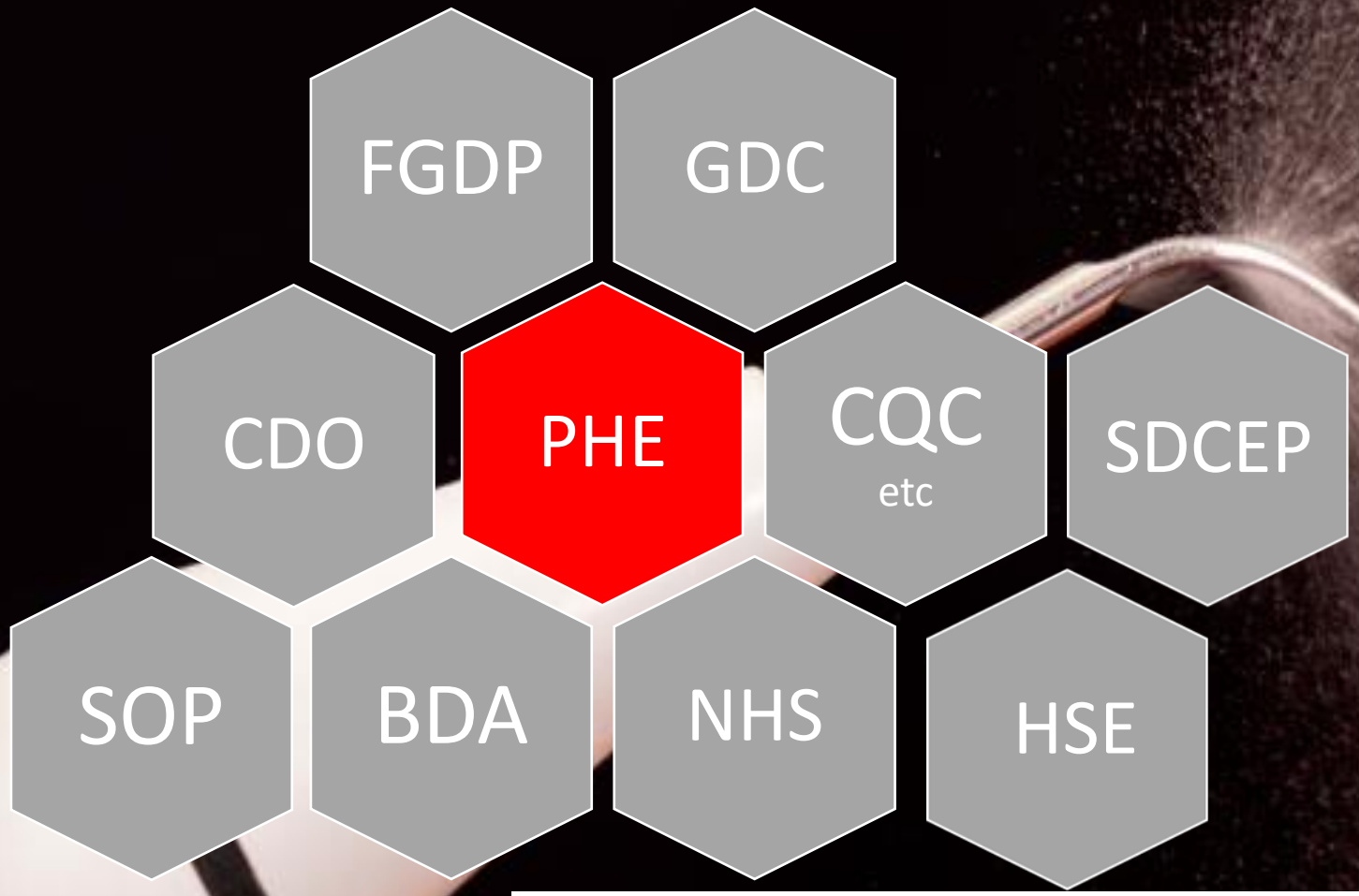


During de-escalation, services in Primary dental care services (GDS and CDS) will be extended for patients without symptoms of COVID 19 from emergency and urgent only to dental cases with dental symptoms (e.g. dental pain but not meeting criteria for urgent), then to cases with a need for treatment without dental symptoms then to routine dental care for all. Aligned to this, the range of treatments offered will be increased, with priority given to treatments to address more severe issues first.

22 May 2020

- 1A, the current phase will be followed by 1b on June 8th when there will be no change to restrictions but all practices will be expected to offer face-to-face urgent dental care in an attempt to maximise the number of patients with urgent needs being treated.
  Patients requiring more complex care will continue to be referred to one of the five urgent dental care centres for treatment by their dentist. These centres will continue to carry out limited Aerosol-generating procedures as appropriate.
- Phase 2, in addition to the current restrictions, practices will be able to offer non-urgent dental care, however, treatments will be limited to those that are non-aerosol generating. Urgent dental care centres will continue during Phase 2.
- Phase 3 will see a return to routine dental care and Aerosol-generating procedures provided in general dental practice. Practices will have to comply with the extant guidance in relation to aerosol settling periods between patients, surgery cleaning and PPE.

Which organisations guidance has primacy?



Public Health England

Academy of Medical Royal Colleges

GIG CYMRU NHS WALES Iechyd Cyhoeddus Cymru Public Health Wales

Health Protection Scotland

HSC Public Health Agency

What if I get it wrong?

What will the GDC say?

General
Dental
Council

"We have no interest in penalising well-grounded professional judgements about how best to meet patients' needs, including where that judgement is to reduce or stop activity"

Responding to COVID-19: caring for patients in uncertain times

18 March, 2020 by Stefan Czerniawski

Share

What if I get it wrong?

What will the GDC say?

General Dental Council

Expert advice on the clinical aspects of COVID-19 will continue to come from the health authorities of the four nations and we will continue to signpost to this guidance as and when it is updated. But that guidance will inevitably not cover every potential scenario, and therefore, **dental professionals will need to continue exercising their professional judgement and weigh the risks in any given situation** .

They will also need to continue to assess whether they are trained, competent and indemnified to carry out the activity in question.

Responding to COVID-19: caring for patients in uncertain times

18 March, 2020 by Stefan Czerniawski

Share

What if I get it wrong?

What will the GDC say?

What will CQC/RQIA/HIW say ?

"CQC understands that there may be inherent risks in carrying out care and treatment, and we will not consider it to be unsafe if providers can demonstrate that they have taken all reasonable steps to ensure the health and safety of people using their services and to manage risks that may arise during care and treatment."

Dentists: information for providers

Categories: Organisations we regulate, Dental service

Coronavirus (COVID-19)

The Chief Dental Officer has set out what dental services must do during the outbreak.

- You should not be providing routine dental care
- Offer telephone triage and advice, giving prescriptions where necessary
- Refer patients who need active emergency treatment to regional urgent care centres where treatment can be provided safely

NHS England is dealing with the setting up of regional urgent care centres. We'll publish more details when we have them.

You do not need to notify us about making these changes, unless you're closing permanently.

What if I get it wrong?

What will the GDC say?

What will CQC/RQIA/HIW say ?

CQC regulate practices NOT individual dentists working in the practice

Current position on dental care services regarding COVID-19 updates

Categories: Organisations we regulate

Following on from previous coronavirus (COVID-19) updates, sent to all dental providers, the Care Quality Commission (CQC) write to confirm the current position.

The decision to offer dental care services is one for the provider to take.

Alongside guidance given by Public Heath England (PHE) and the General Dental Council (GDC), CQC encourage dental providers to give proper consideration to the communications from the Chief Dental Officer (CDO) regardless of whether their practice is NHS, private, or mixed.

CQC cannot require providers of dental care services to close, unless we find clear evidence of a breach of our regulations that requires consideration of the use of our powers under the Health and Social Care Act 2008 and associated regulations.

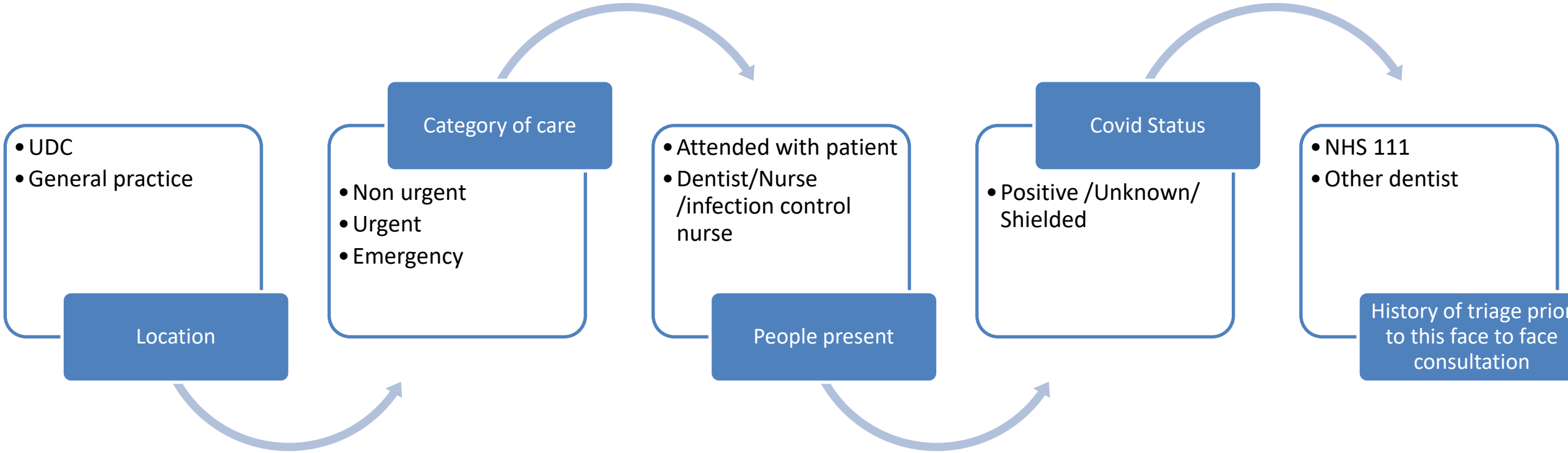
As part of our regulatory function we will assess the extent to which providers are providing an appropriate level of safety within the context of our regulations. In doing so we will refer to prevailing guidance, not limited to but including guidance from PHE, the CDO and GDC to help us reach a judgement on the extent to which the service currently being provided complies with our Regulations.

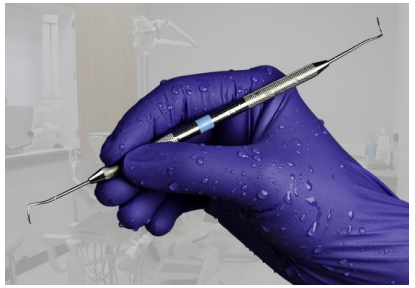
Last updated: 19 May 2020

If it isn’t written down, then it didn’t happen

THE CLINICAL RECORDS

People will soon forget the context of COVID19 and what was happening at a particular time


Location
• UDC
• General practice
Category of care
• Non urgent
• Urgent
• Emergency
People present
• Attended with patient
• Dentist/Nurse /infection control nurse
Covid Status
• Positive /Unknown/ Shielded
History of triage prior to this face to face consultation
• NHS 111
• Other dentist



Standard record keeping requirements

- Name
- Contact details
- DOB
- Medical history
- Reason for attendance
- Radiographs- justification/evaluation/quality grade

Examination

- History of present complaint
- Extra oral/intra oral
- Special tests

Diagnosis

- Treatment plan
- Options- risks and benefits of having/not having the treatment
- Consent

Treatment

- PPE used
- AGP or non AGP
- Other risk mitigations eg high vol suction/rubber dam /mouthwash
- -Down time between appointments – start and finish of procedure
- Follow up

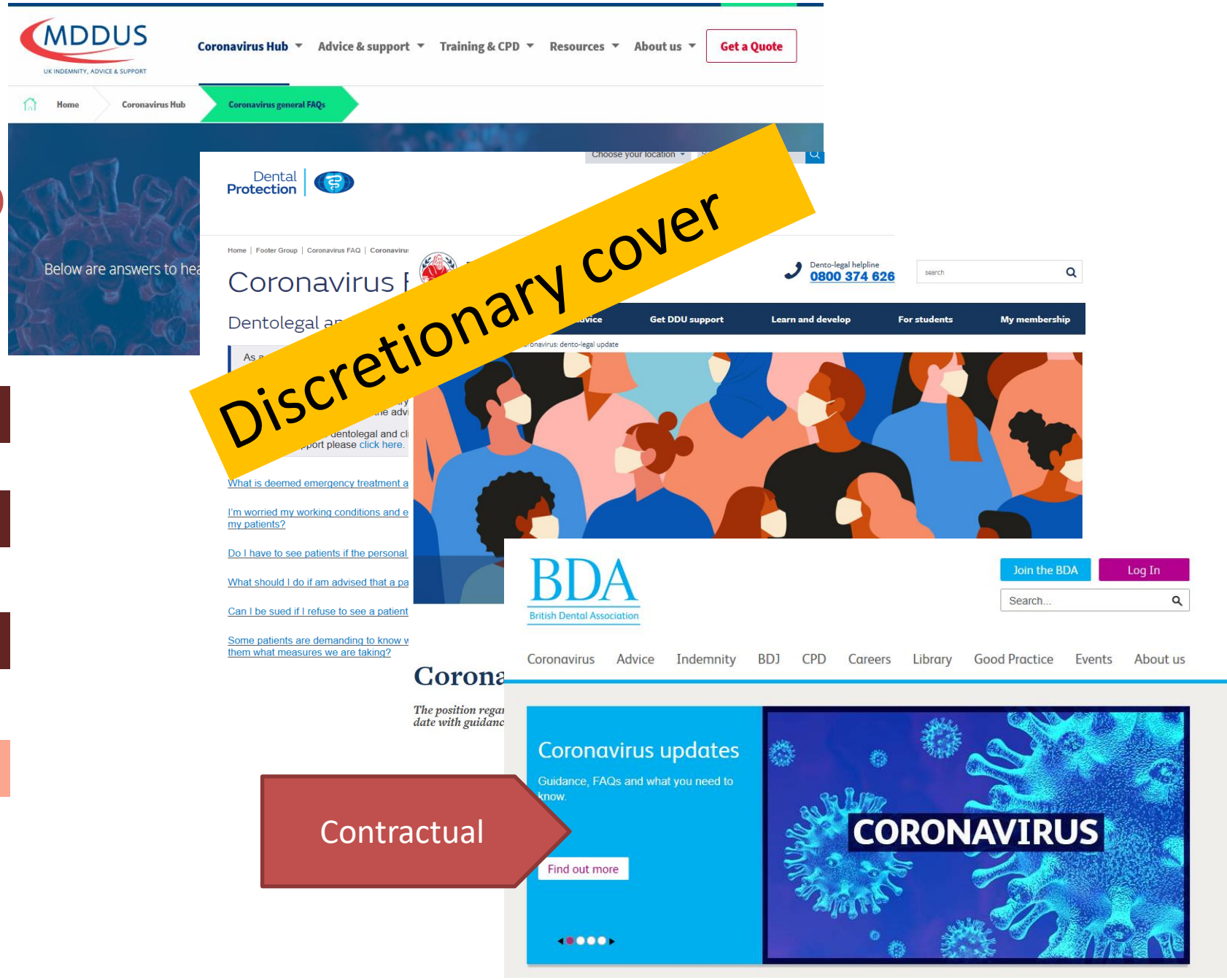
What if I get it wrong?

What will the GDC say?

What will CQC/RQIA/HIW say ?

What will patients lawyers say?

What will your indemnity providers say?



Contractual

Will my indemnity provider cover me to do fit testing?

BDA Indemnity will cover the policyholder to do fit testing for their own and other practices

If the BDA indemnity policyholder is a practice owner , an employed member of their staff will be covered to do the fit testing for their own practice

Honorary contract

NHS England

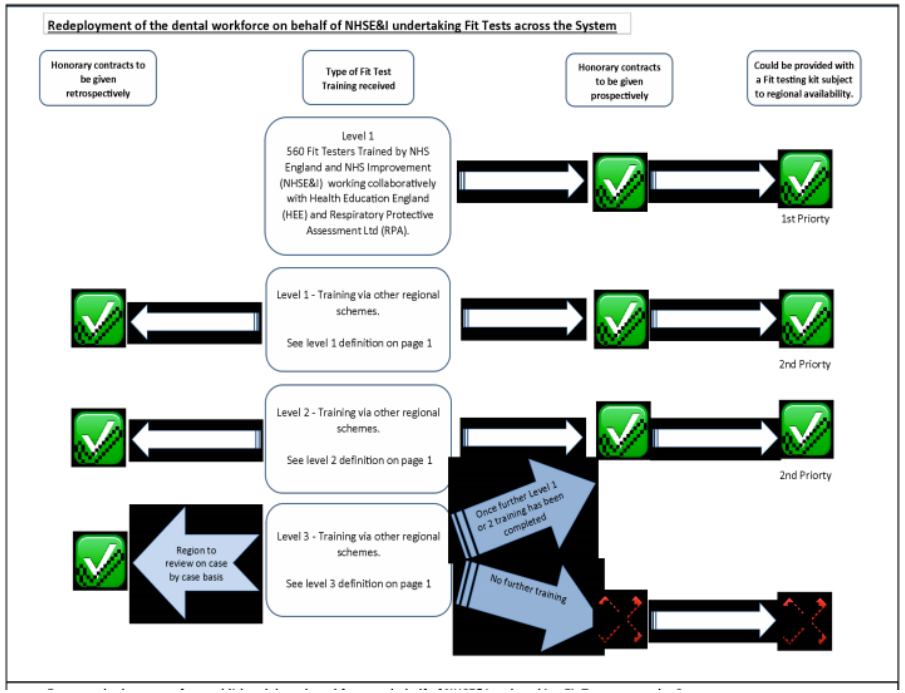
The honorary contract will provide, depending on the circumstance, prospective and or retrospective liability cover for the fit testing undertaken across the system on behalf of NHSE&I.

INDEMNITY

You will be indemnified for your duties relating to the fit testing of NHS Dental Staff under this agreement. You will be covered by NHSEI's membership of the Clinical Negligence Scheme for Trusts (CNST) and the Liabilities the Third Parties Scheme (LTPS) for all liabilities including clinical negligence and another third party liabilities that may arise under this honorary contract.

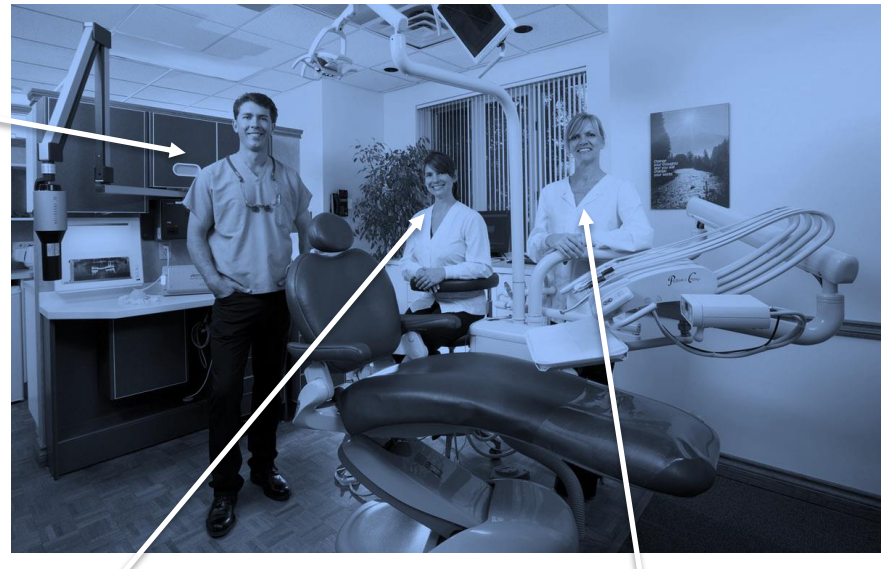
DURATION

Subject to earlier termination within the de-escalation of the COVID-19 Response process, this agreement will terminate automatically without further notice on 31st March 2021 unless extended by agreement of the parties to a later date.



Who is the practice owner responsible for?

Associate dentist ? Foundation dentist?



Nurse?

Receptionist ?

If the receptionist doesn't book the patient in because they don't realise the urgency of the matter?

If the associate triaging incorrectly advises the patient?

If the Foundation dentist separates an endodontic instrument whilst you were supervising them?

Dear Mr Dentist

Our clients case relates to treatment provided by Dr A, Dr B and Dr C who treated our client at your practice.
We understand that the said practice had been operated by you from Dec 1999 to date.

As practice owner , you are directly liable for any negligence of any clinical staff at your practice, regardless of their employment status (Cox v MOJ [2016] UKSC 10) followed by Barclays Bank v Various Claimants [2018]EWCA Civ 1670 in relation to self-employed independent contractor and directly liable for the negligence of any clinical staff at the practice, again regardless of their employment status, pursuant to a non -delegable duty of care to the patients of the practice (Woodland v Essex County Council [2013] UKSC 66

Yours sincerely

we sue dentists. com

BDA
British Dental Association

DENTISTS' PROFESSIONAL LIABILITY INSURANCE

Policy wording

Lloyd & Whyte RSA

6 Vicarious Liability

The Company will provide indemnity to the Policyholder in respect of legal liability arising from Dentistry undertaken by an individual for whom the Policyholder is vicariously liable

This Extension will not apply in respect of legal liability

A) when that individual was acting outside of the terms and conditions of their employment or contract or

B) where applicable, the Policyholder did not make reasonable efforts to ensure that the individual held appropriate cover

during the period of time within which the individual worked for or with the Policyholder

Vicarious liability

Dr Kevin Lewis

The 'Perspective' article on pages 6-8 summarises the far-reaching legal reforms that were introduced in April 2013[1], which forced a group of notorious 'no win-no fee' law firms targeting dentists, to search for new ways to replace the income they had lost as a result of the legislative changes.

One of their favoured tactics is to allege that the owner of a dental practice is vicariously liable for the negligent acts and omissions of any member of staff working in or for the practice – even if the person who carried out the treatment was a self-employed associate dentist.

Put simply, the well-established legal principle of vicarious liability means that an employer can be held responsible for the negligent acts and omissions of an employee. There is an assumption that in such a relationship, there is an element of control, direction, oversight and supervision that comes with the relative power, seniority and authority of the employer. In short, the employer makes the rules and the employee follows them. The employee is integrated into the employer's organisation and has very little autonomy and independence.

Over time, the courts have come to recognise that modern working relationships are often not a true employer-employee relationship at all. But each court is free to decide whether or not a particular working relationship, however it is described contractually or intended to operate, is 'akin to employment' and whether the owner of a practice has an over-riding duty of care owed to all patients treated in the practice, that cannot simply be delegated to a third party – even if it is that third party who actually treats the patient.

The greater the level of control exerted by the practice owner and the more unequal the balance of power and freedom to act independently and make decisions, the more difficult it becomes to deny that such a duty of care, and vicarious liability, exists.

Sometimes, the dentist who carried out the treatment may have left the UK and/or is no longer registered, and untraceable for the purpose of pursuing the claim. In addition, the situation could arise that a dentist has no access to indemnity (or was refused indemnity), so the 'no win-no fee' law firms have a strong financial interest in giving themselves a second bite of the cherry. So they are increasingly targeting practice owners in addition to (or sometimes, instead of) the associate, and often stating unequivocally - and incorrectly - "As practice owner , you are directly liable for any negligence of any clinical staff at your practice, regardless of their employment status." One has even asserted that "practice owners are now responsible, and potentially legally liable, for treatment provided by every associate they employ, and have ever employed, including those who have long since departed from their practice."

Some of the 'no win-no fee' firms will start to run these speculative vicarious liability arguments against practice owners from the very earliest stages in case correspondence, even when the associate who treated the patient is known to have their own indemnity. This is not just a 'belt and braces' strategy: it less obviously creates an opportunity for the claimant's solicitors to generate significant additional fees from over-working these preliminary arguments, perhaps involving more than one indemnity provider. Obscenely high legal costs have sometimes been claimed using this ploy and this compounds the pain for any practice owner who has discovered that they have no cover for vicarious liability claims and the associated costs, which can be considerable.

Social justice

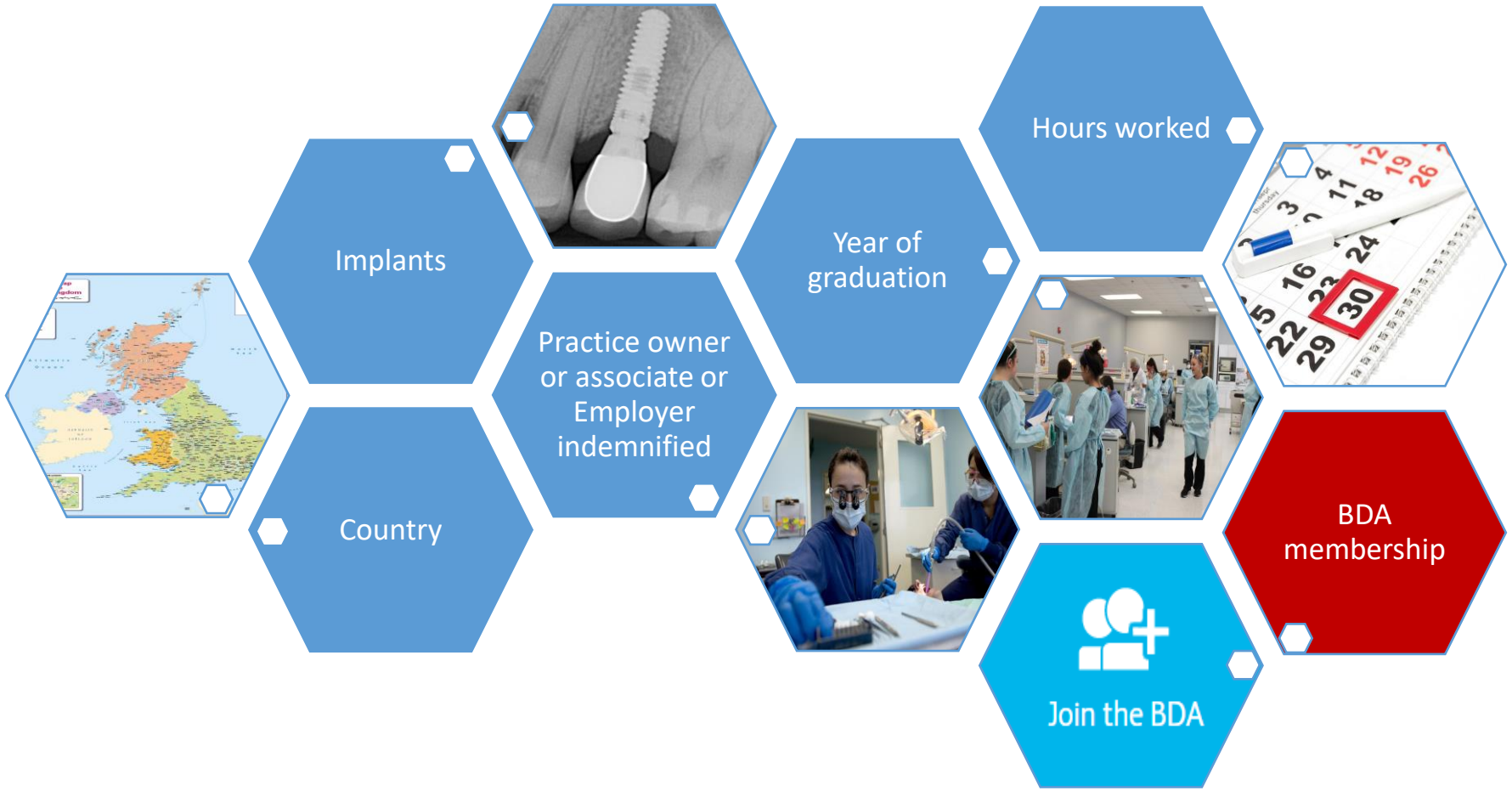
In some recent cases, the courts have clearly found it unacceptable that a deserving claimant can be denied access to compensation properly due to them, simply because of the associate and practice owner's working, contractual and indemnity arrangements. In one recent case the further question arose of whether, as a principle of social justice and public policy, it was right that the NHS and NHS bodies should be able to walk away from any responsibility for dental services that they had elected to commission, leaving the practice owner(s)/provider(s) and performer(s) to carry the can.

Summary

A potential and growing risk certainly exists for practice owners, whose indemnity may or may not cover vicarious liability. BDA Indemnity was designed to eliminate this uncertainty and meet this new threat head-on. Further background and practical advice can be accessed from the website[3].


Get a quote on-line

How much will it cost?



Eligibility for the Indemnity product

Practice owners	Associates	NHS/Employee/Crown indemnified
• Must be in Expert tier	• At least in Extra tier • Expert if they have stake in the practice	• Essential if exclusively doing NHS/Employer etc • Extra or Expert as above plus independent work

When you need it …you want to be sure it is there

BDA
British Dental Association
Indemnity

len.dcruz@bda.org