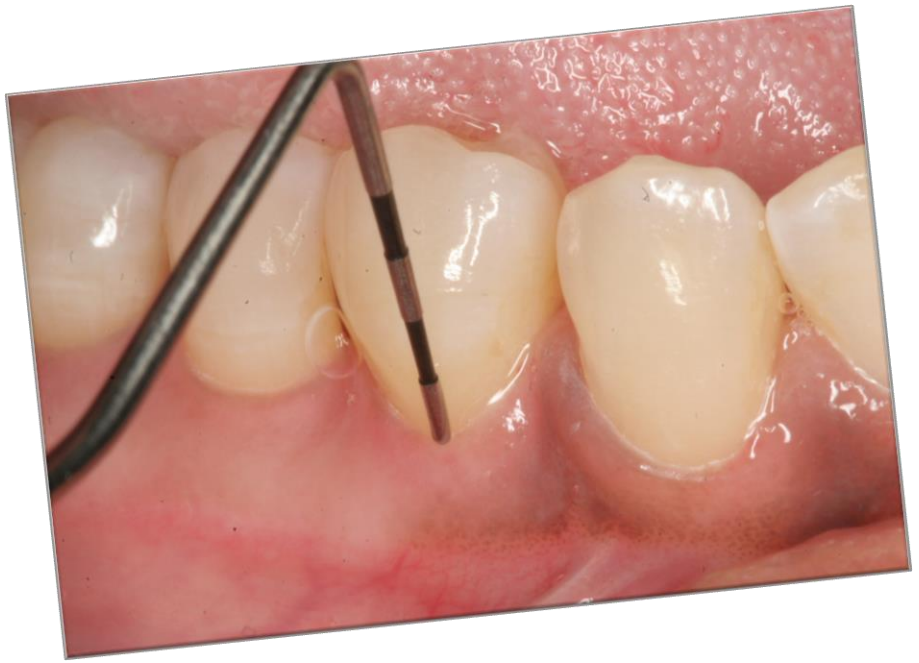
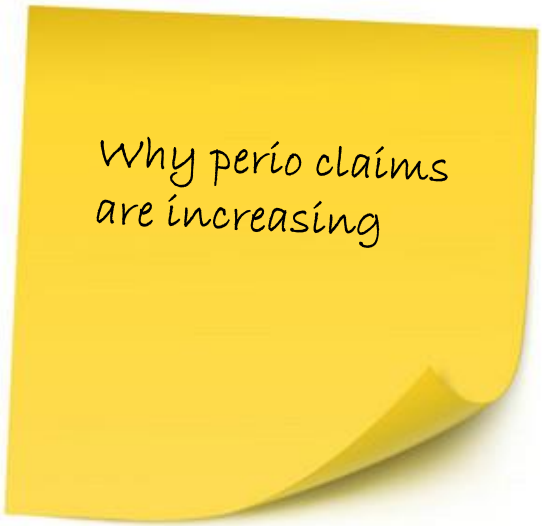
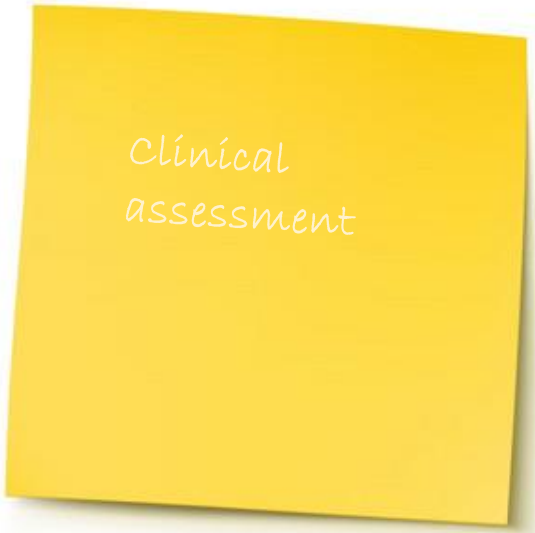
Down in the mouth- managing the dento-legal risks of periodontal disease in practice

BDIA Birmingham
October 2019

Len D’Cruz




Why perio claims are increasing


Clinical assessment


Record keeping

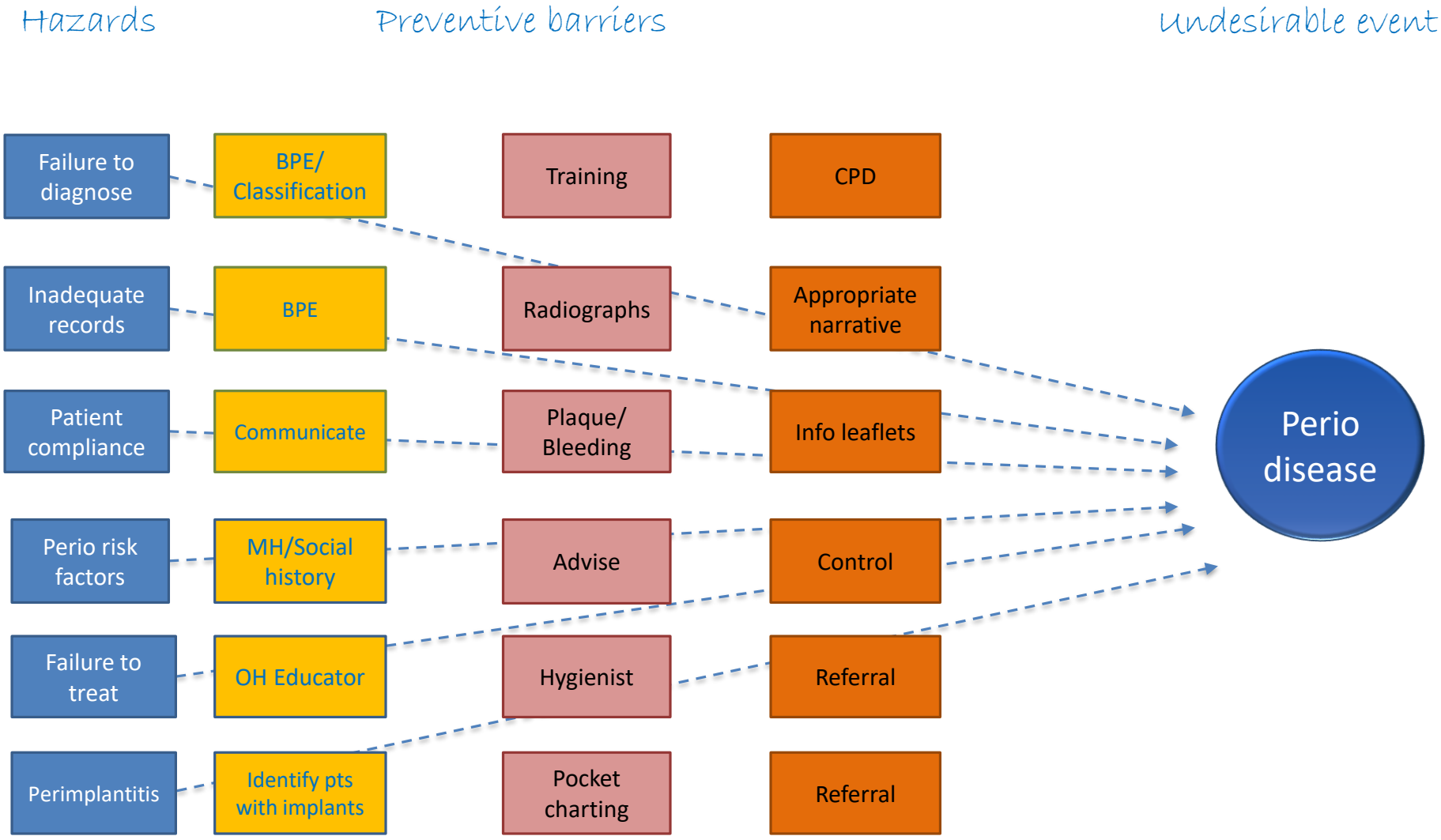

Referrals to hygienist and specialists


Managing periodontal patients on the NHS

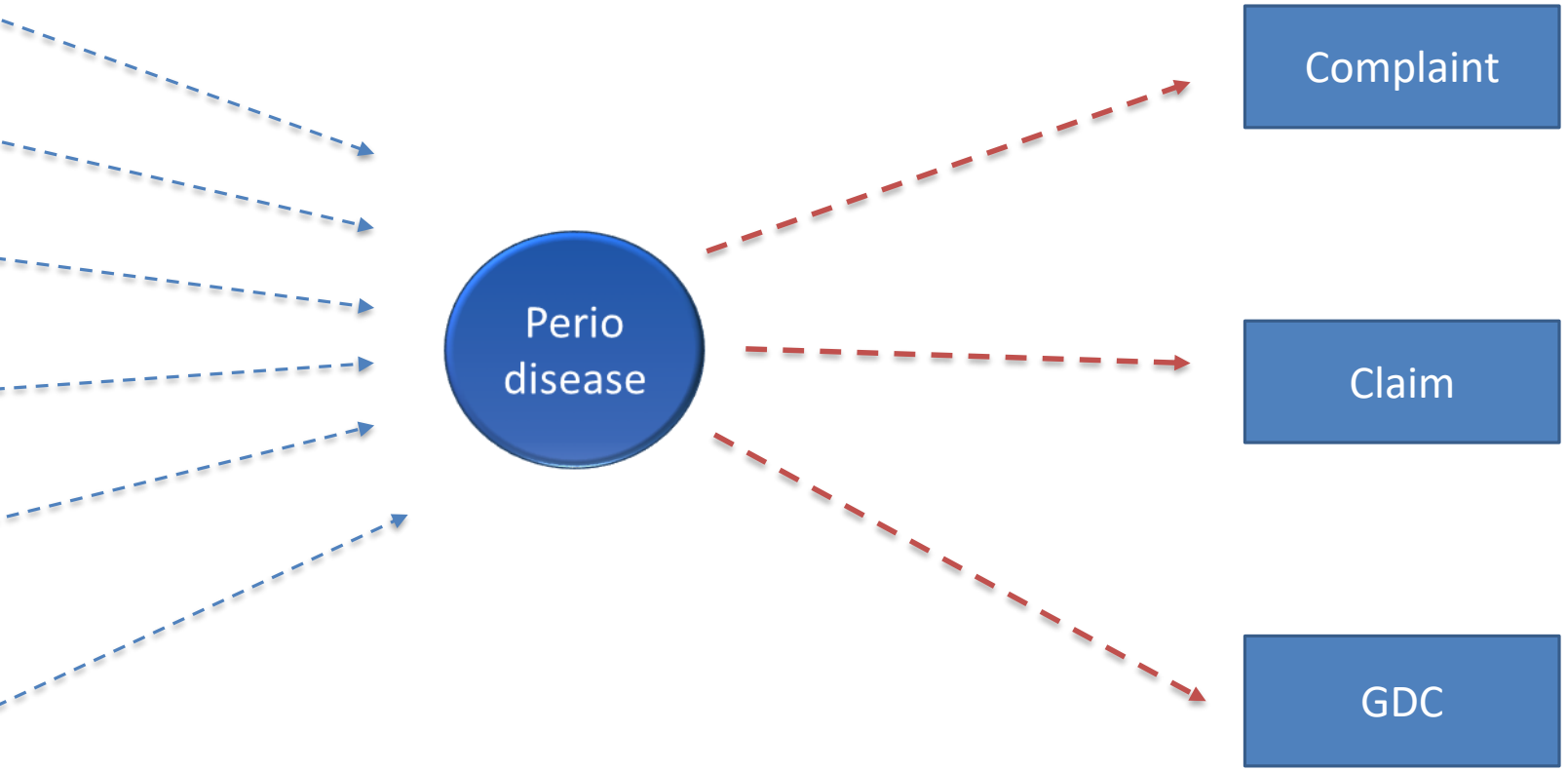

BDA Indemnity

Common allegations

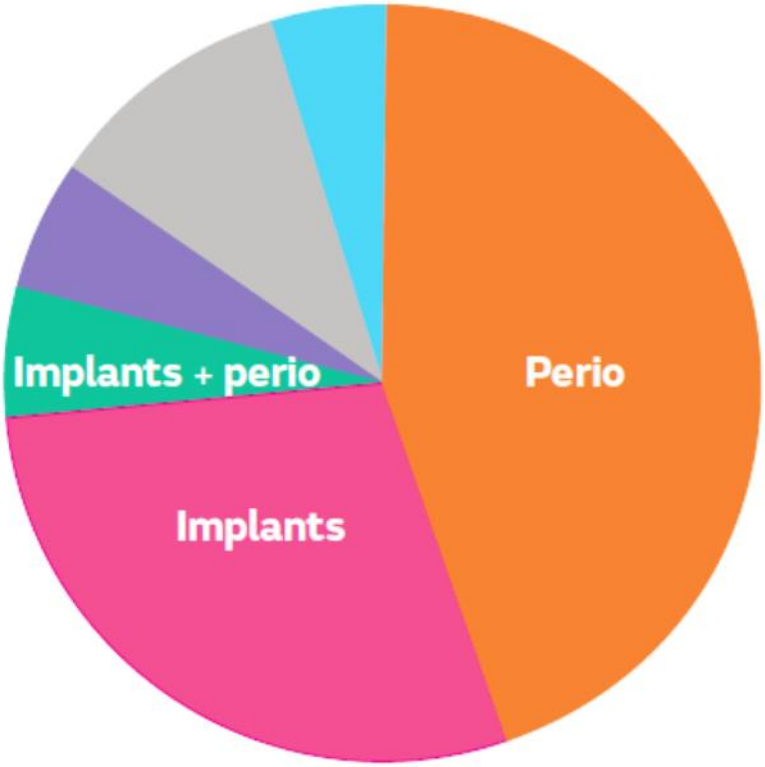
- Failure to diagnose periodontal disease
- No evidence of periodontal monitoring or risk assessment made
- No or insufficient periodontal treatment carried out
- No management of risk factors
- No referral made or offered when it was appropriate to do so


Hazards
Preventive barriers
Undesirable event
Failure to diagnose
BPE/ Classification
Training
CPD
Inadequate records
BPE
Radiographs
Appropriate narrative
Patient compliance
Communicate
Plaque/ Bleeding
Info leaflets
Perio risk factors
MH/Social history
Advise
Control
Failure to treat
OH Educator
Hygienist
Referral
Perimplantitis
Identify pts with implants
Pocket charting
Referral
Perio disease

Consequences



Top 20 UK claims by value
Perio 44.7%
Implants 28.8%
Implants and perio 5.5%
Maxillofacial 5.5%
Orthodontics 10.5%
Other 5%



Why is perio such a problem?

- Perio cases cover extended periods often stretching back many years , involving more than one practitioner and hygienist
- More than half of defence organisations high value perio cases included treatment carried out in the 1980's and 1990's
- Law firms place "advertorials" in local papers naming the dentist whom they have won perio claims against and invite other such patients with bleeding gums to contact them

Year on year increase in number of perio related claims
1,300 perio claims in 2016

200 perio claims per year which are more than 10 years old

Average perio claim settlement £45,000
Average non -perio claim settlement £22,000

Special damages are higher than general damages

Why is perio such a problem?

10. **Non-Surgical Treatment**

10(a) Scaling, polishing and simple periodontal treatment, including oral hygiene instruction, normally only payable where at least two complete calendar months have elapsed since the last such treatment:

		Dentist's Fee	Patient's Charge
1001	**per course of treatment**	£11.10	(£8.88)

10(b) Treatment of periodontal disease requiring more than one visit, including oral hygiene instruction, scaling, polishing and marginal correction of fillings:

1011	**per course of treatment**	£26.90	(£21.52)

10(c) Non-surgical treatment of chronic periodontal disease, including oral hygiene instruction, over a minimum of three visits, with not less than one month between the first and third visit, and with re-evaluation of the patient's condition (to include full periodontal charting) at a further visit not less than two complete calendar months after active treatment is complete. Treatment to include root-planning, deep scaling and, where required, marginal correction of restorations, irrigation of periodontal pockets, sub-gingival curettage and/or gingival packing of affected teeth, and all necessary scaling and polishing:

	with 1–4 affected teeth treated under this item	£34.25	(£27.40)
	with 5–9 affected teeth treated under this item	£41.85	(£33.48)
	with 10–16 affected teeth treated under this item	£49.40	(£39.52)
1021	**with 17 or more affected teeth treated under this item**	£55.45	(£44.36)

Additional fee payable in connection with item 10(c) for each sextant of the mouth treated:

1022	**per sextant**	£6.95	(£5.56)

10(d) This item has been deleted

*10(e) Splinting of periodontally compromised teeth:

1041	**such fee as the Board may determine**		

- The end of item-of –service and the detailed fee scale narrative that went with periodontal claims for treatment disappeared with the UDA system
- The SDR narrative required BPE scores and other indices to be measured for different levels of exams and perio treatment (10c)
- 13 years worth of the 2006 contract and the unintended consequences of it will cost millions to resolve

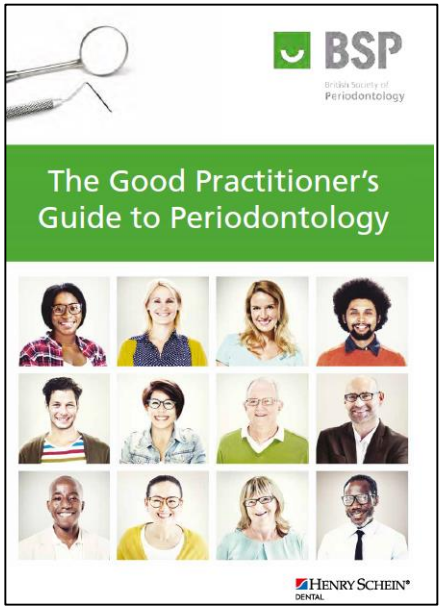
Why is perio such a problem?

- Future treatment costs are large and there are more of them. Most claims cost between £25,000 and £75,000 to settle but many of them cost £100,000 or more
- Record keeping does not match what the dentist and hygienists say they told the patients about OHI, smoking , risk factors and progression of the disease
- Few clinicians can be entirely confident that no such cases are lurking in their filing cabinets from 10-20 years ago


Why perio claims are increasing
Clinical assessment
Record keeping
Referrals to hygienist and specialists
Managing periodontal patients on the NHS
BDA Indemnity

Periodontal assessment

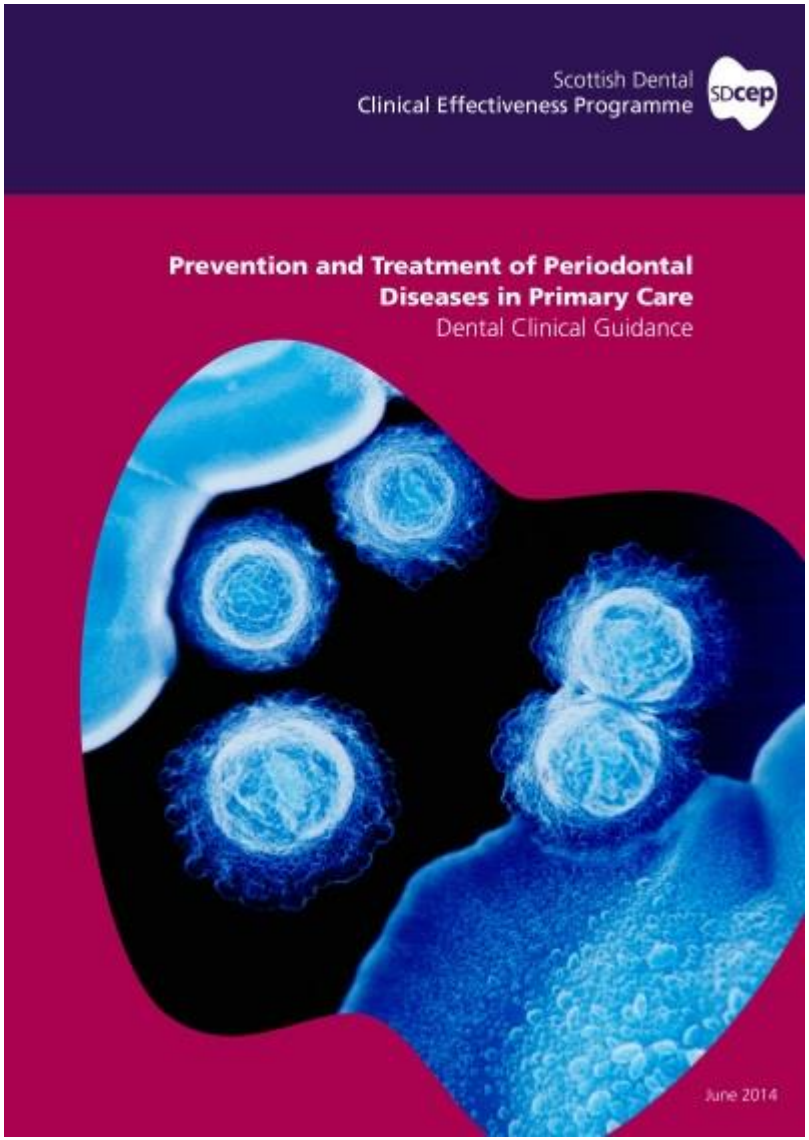
Follow BSP guidance



- **History taking**

1. Do your gums bleed on brushing or overnight?
2. Are any of your teeth loose?
3. Can you chew everything you want to?
4. Do you have a bad taste or smell from your mouth?
5. Do you suffer from pain, swelling, gumboils or blisters?
6. Do you smoke?
7. Is there anything else you would like to tell me?

- **Risk factors**
  - Local
  - Smoking
  - Diabetes
  - Stress
  - Medication
- **Periodontal screening**
  - BPE
- **Radiographs**
  - Horizontal /vertical bite wings
  - Periapicals
- **Classification of periodontal disease**



Scottish Dental
Clinical Effectiveness Programme


Why perio claims are increasing
Clinical assessment
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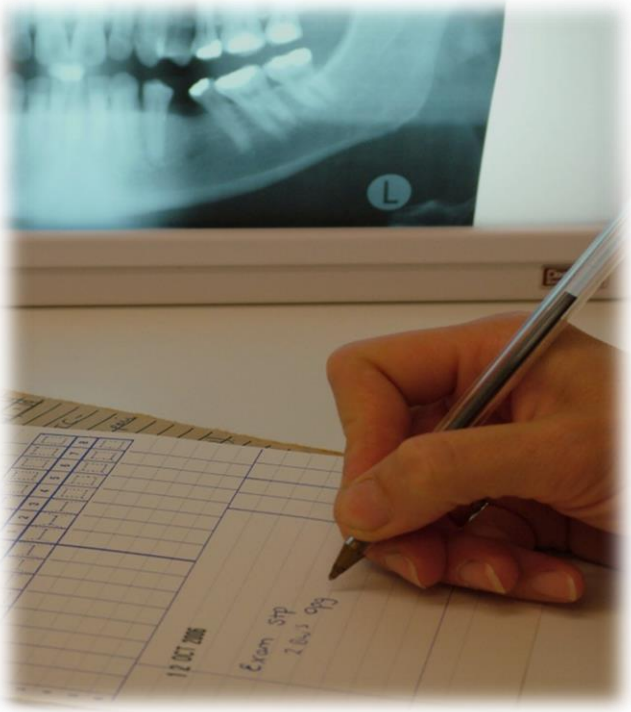
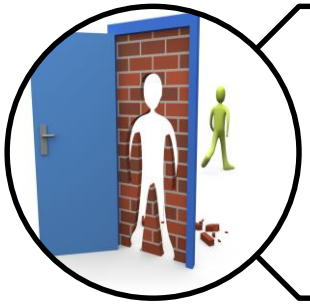


The clinical records

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

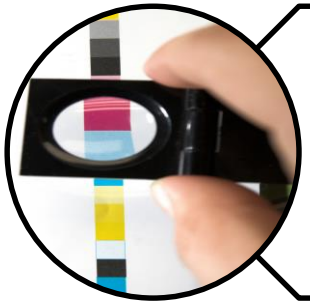
By looking at the card:

- Who was present
- What was said
- What was done
- Why is it being done
- How is it being done
- What was paid
- What is being planned for the future



Concern

- Patient report
- Use patient's own words



Tests and findings

- What you did and what you found out
- Special tests and reports

Diagnosis

- What conclusion did you draw
- Final or Provisional

Treatment proposals

- What options are there?
- Costs
- Timings

Consent

- Has the patient been given the pros and cons
- Evidence of agreement

Progress notes

- Risk related record keeping

Most of what we do in practice is repetitive

It is the **why** that we do it that may change depending on the patient or the clinical situation

That is when your notes need to be more detailed

Basic periodontal examination (BPE)

Routine

Table 1: Summary of codes used in BPE and their clinical description

Code	*Examination Findings*	*Clinical Condition*
0	No pockets exceeding 3 mm, no calculus or overhangs and no bleeding on gentle probing	Periodontal health
1	Coloured band remains totally visible, indicating no pockets exceeding 3 mm, no calculus or overhangs but bleeding present on gentle probing	Gingivitis
2	Coloured band remains totally visible, indicating no pockets exceeding 3 mm, but calculus or other plaque–retentive factors found at or below the gingival margin	Gingivitis complicated by local risk factors
3	Coloured band on probe remains partially visible when inserted into the deepest pocket, indicating pocket depths greater than 3.5 mm but less than 5.5 mm	Mild periodontitis
4	Coloured band on probe disappears, indicating a pocket of at least 6 mm in depth	Moderate or advanced periodontitis
*	Total attachment loss at any site is 7 mm or greater or if a furcation defect is probed.	Advanced periodontitis

CLINICAL | VERIFIABLE CPD PAPER
Periodontics

Periodontal diagnosis in the context of the 2017 classification system of periodontal diseases and conditions – implementation in clinical practice

T. Dietrich, [1] P. Ower, [2] M. Tank, [3] N. X. West, [4] C. Walter, [5] I. Needleman, [6] F. J. Hughes, [7] R. Wadia, [8] M. R. Milward, [9] P. J. Hodge, [10] I. L. C. Chapple,*[9] on behalf of the British Society of Periodontology

Key points

- Describes BSP recommendations for the implementation of the 2017 classification of periodontal diseases and conditions in UK dental practice.
- Illustrates a diagnostic pathway for patients with dental biofilm-induced periodontitis, building on the BPE.
- Describes grading and staging of periodontitis and assessment of current periodontal status to reach a diagnostic statement.

The 2017 World Workshop Classification system for periodontal and peri-implant diseases and conditions was developed in order to accommodate advances in knowledge derived from both biological and clinical research, that have emerged since the 1999 International Classification of Periodontal Diseases. Importantly, it defines clinical health for the first time, and distinguishes an intact and a reduced periodontium throughout. The term 'aggressive periodontitis' was removed, creating a staging and grading system for periodontitis that is based primarily upon attachment and bone loss and classifies the disease into four stages based on severity (I, II, III or IV) and three grades based on disease susceptibility (A, B or C). The British Society of Periodontology (BSP) convened an implementation group to develop guidance on how the new classification system should be implemented in clinical practice. A particular focus was to describe how the new classification system integrates with established diagnostic parameters and pathways, such as the basic periodontal examination (BPE). This implementation plan focuses on clinical practice; for research, readers are advised to follow the international classification system. In this paper we describe a diagnostic pathway for plaque-induced periodontal diseases that is consistent with established guidance and accommodates the novel 2017 classification system, as recommended by the BSP implementation group. Subsequent case reports will provide examples of the application of this guidance in clinical practice.

Background and context

The 2017 World Workshop Classification system for periodontal and peri-implant diseases and conditions was developed in order to accommodate advances in knowledge derived from both biological and clinical research that have emerged since the 1999 International Classification of Periodontal Diseases. The aim, as determined by the joint European Federation of Periodontology (EFP) and American Academy of Periodontology (AAP) management committee, was to adopt a reductionist model in order to create a system that could be implemented in general dental practice, the environment where over 95% of periodontal disease is diagnosed and managed. A further aim was to create a system that captured and distinguished the severity and extent of periodontitis (a reflection of the amount of periodontal tissue loss) on one hand, as well as a patient's susceptibility for periodontitis (as reflected by the historical rate of periodontitis progression). In addition, the system needed to accommodate the current periodontal status of a patient (probing pocket depth [PPD], and percentage of bleeding on probing [BoP]). The classification is a live system to be regularly updated by a task force to accommodate future advances in knowledge, either clinical or biological (for example, biomarkers), as it emerges.

In order for a clinician or student to understand periodontal assessment and diagnosis in the context of the 2017 classification system, it is critical to understand that the first step is to determine the type of periodontal disease (Table 1).

For the first time, the 2017 classification system gives clear definitions of periodontal health and gingivitis for:

- Patients with an intact periodontium
- Patients with a reduced periodontium due to causes other than periodontitis
- Patients with a reduced periodontium due to periodontitis.

For a detailed discussion of the evidence and rationale behind these definitions, the reader is referred to the consensus paper of workgroup one of the 2017 World Workshop.[1]

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BSP
British Society of Periodontology

Implementing the 2017 Classification of Periodontal Diseases to Reach a Diagnosis in Clinical Practice

Scan me

History, examination and screening for periodontal disease
including BPE and assessment of historic periodontitis (interdental recession)

Code 0 / 1 / 2
with no obvious evidence of interdental recession

- <10% bleeding on probing → **Clinical Gingival Health**
- 10-30% bleeding on probing → **Localised Gingivitis**
- >30% bleeding on probing → **Generalised Gingivitis**

Diagnosis should also include a comment on plaque retentive factors where a BPE code 2 is present

Code 3
with no obvious evidence of interdental recession

Appropriate radiographic assessment

Initial periodontal therapy and review in 3 months with localised 6-point pocket chart in involved sextant(s)

- No pockets ≥4mm and no radiographic evidence of bone loss due to periodontitis → *continue with code 0/1/2 pathway*
- Pockets ≥4mm remain and/or radiographic evidence of bone loss due to periodontitis → *continue with code 4 pathway*

Code 4
and/or obvious evidence of interdental recession

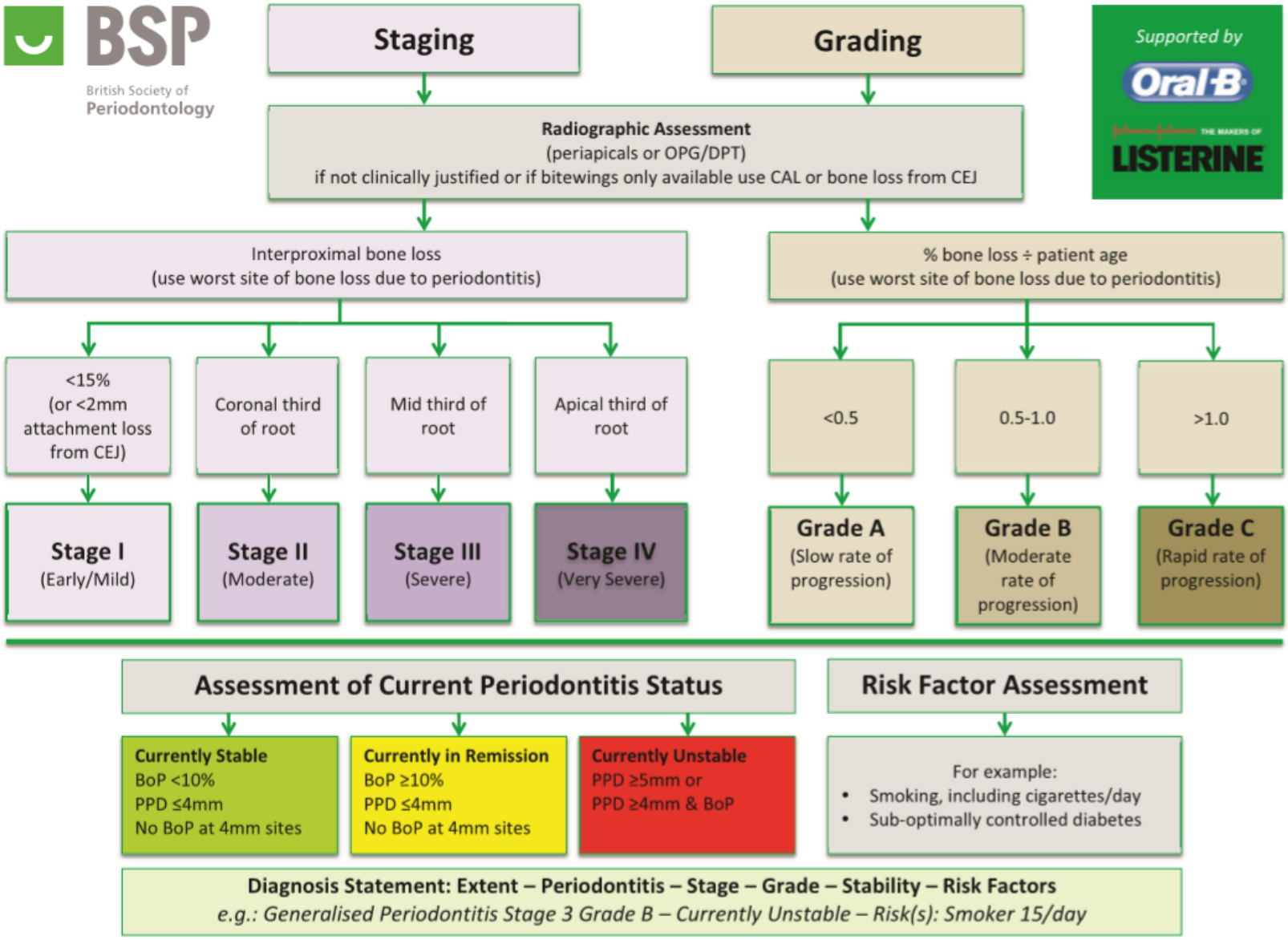
Appropriate radiographic assessment

Full periodontal assessment
(including detailed 6-point pocket chart)

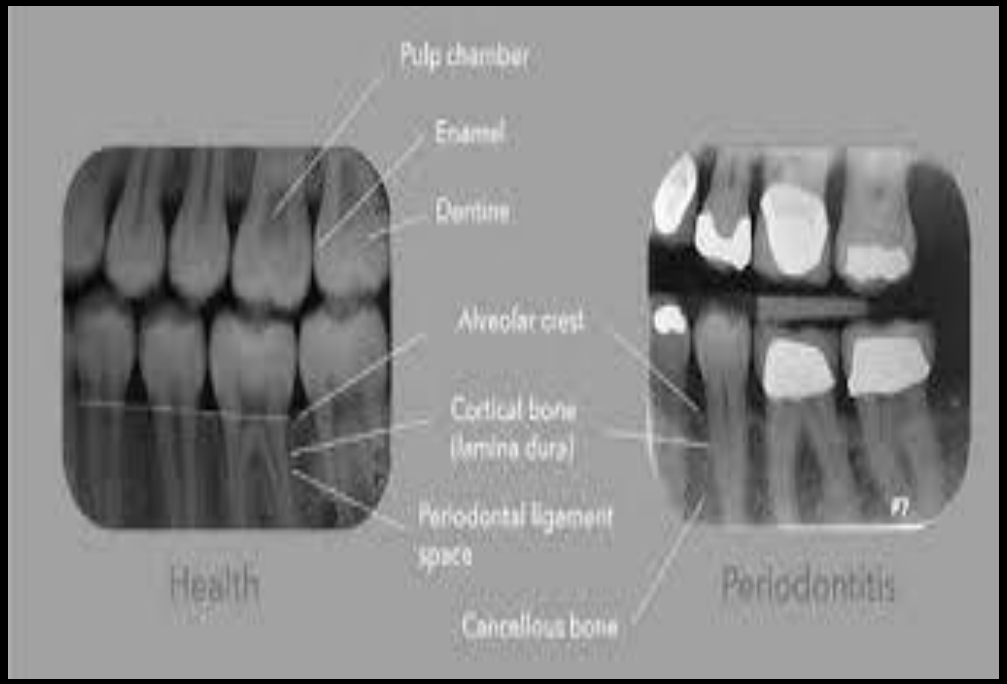
- Molar-incisor pattern → **Periodontitis Molar-Incisor Pattern**
- <30% of teeth → **Localised Periodontitis**
- ≥30% of teeth → **Generalised Periodontitis**

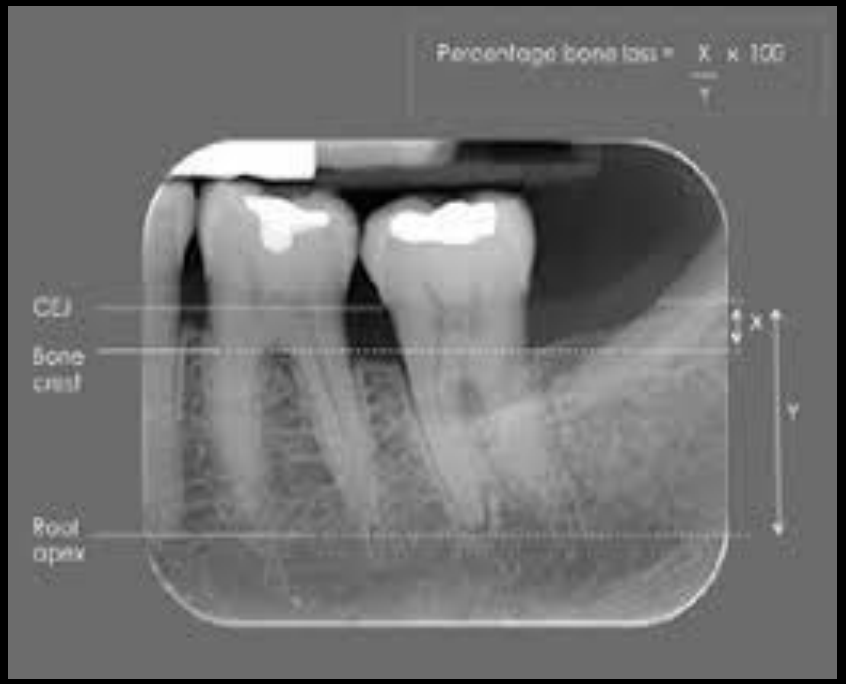
Staging and grading, current disease status and risk factor assessment
(PTO)

www.bsperio.org.uk


BSP
British Society of Periodontology
Staging
Grading
Supported by
Oral-B
THE MAKERS OF
LISTERINE
Radiographic Assessment
(periapicals or OPG/DPT)
if not clinically justified or if bitewings only available use CAL or bone loss from CEJ
Interproximal bone loss
(use worst site of bone loss due to periodontitis)
% bone loss ÷ patient age
(use worst site of bone loss due to periodontitis)
<15% (or <2mm attachment loss from CEJ)
Coronal third of root
Mid third of root
Apical third of root
<0.5
0.5-1.0
>1.0
Stage I (Early/Mild)
Stage II (Moderate)
Stage III (Severe)
Stage IV (Very Severe)
Grade A (Slow rate of progression)
Grade B (Moderate rate of progression)
Grade C (Rapid rate of progression)
Assessment of Current Periodontitis Status
Risk Factor Assessment
Currently Stable
BoP <10%
PPD ≤4mm
No BoP at 4mm sites
Currently in Remission
BoP ≥10%
PPD ≤4mm
No BoP at 4mm sites
Currently Unstable
PPD ≥5mm or
PPD ≥4mm & BoP
For example:
• Smoking, including cigarettes/day
• Sub-optimally controlled diabetes
Diagnosis Statement: Extent – Periodontitis – Stage – Grade – Stability – Risk Factors
e.g.: Generalised Periodontitis Stage 3 Grade B – Currently Unstable – Risk(s): Smoker 15/day

When should I start using the new perio classification?





BSP Good Practitioners guide

CLINICAL RECORDS AND RADIOGRAPHS

Allegations

- Failure to diagnose periodontal disease
- No evidence of periodontal monitoring or risk assessment made
- No appropriate periodontal treatment carried out
- No referral made

WE CAN PROTECT OURSELVES AND OUR PATIENTS

What is expected of a GDP?

- Adequate screening (BPE)
- A diagnosis and INFORMING THE PATIENT
- Reasonable standard of NSPT
- An assessment of the treatment outcome
- A long term plan/long term care
- Referral if necessary
- Good standard of record keeping

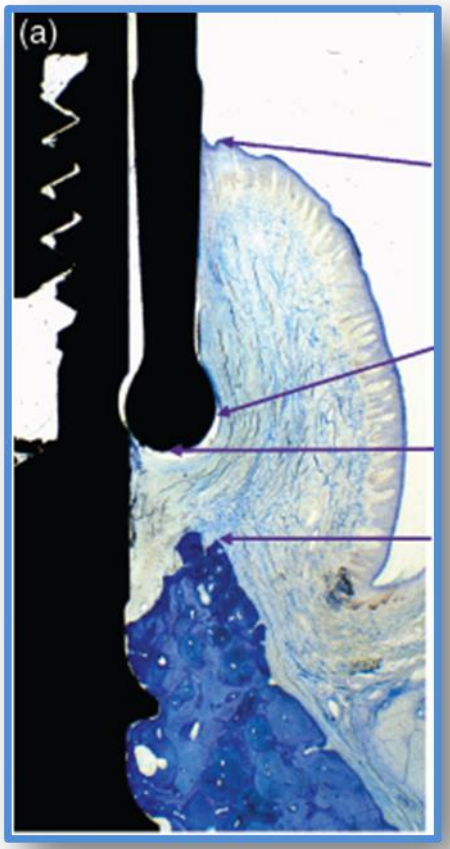
Dento-legal risks for the GDP?

- No BPEs
- No pocket measurements for codes 3 and 4
- Lack of and /or poor quality radiographs
- 15 min S/P is not adequate RSI
- Poor quality OHI and lack of smoking cessation
- Can not just ‘ref to hygienist’-the GDP needs to take control/ oversee care
- NHS Vs PVT hygiene appointments
- No definitive decisions or assessments made about where the patient is going
- Ignoring implants

"Registrants who do not place or restore implants may see patients that have implants in-situ and they could be vulnerable to a complaint or a claim, if they do not diagnose in a timely manner the development of peri-implantitis"

Dental Protection 2015

Peri-implantitis - ≥1mm of bone loss after the first year of installation together with bleeding and/or suppuration (Sanz & Chapple 2012)



SHOULD YOU BE CHECKING FOR POCKETS AROUND IMPLANTS (WITH A METAL PROBE)?

YES YOU SHOULD

Useful phrases to include in templates

"Patient advised they are at risk of developing destructive periodontal disease"

"Patient warned of tooth mobility and tooth loss related to periodontitis"

"Patient advised on staging/grading and current disease status

"Patient advised smoking increases risk of periodontitis, poorer response to treatment and increases chance of reoccurrence"

Useful phrases to include in templates

"Patient advised poorly controlled blood sugar levels in diabetes related to poorer response to periodontal therapy"

"Patient shown how to use interdental brushes and advised on sizes:"

"Patient warned of post-operative sensitivity, gingival recession and black triangle appearance after periodontal treatment"


Why perio claims are increasing
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BDA Indemnity

CAN I REFER MY NHS PATIENTS TO SEE THE HYGIENIST PRIVATELY?

To refer or not refer – that is the question

by Len D'Cruz,
Dento Legal Adviser,
Dental Protection

The NHS dental contract is designed primarily to provide the necessary treatment to secure a patient's oral health.

Whilst the contract takes different forms in England and Wales with UDAs being the metric of choice and Scotland and Northern Ireland retaining a fee per item remuneration model, the delivery of care is predicated on need rather than want.

Many practices have built success on 'mixed practices', that is the delivery of private care alongside NHS dental care to individual patients.

The rules around mixing in England and Wales are quite clear. A dentist may, with the consent of the patient, provide privately any part of a course of treatment (except sedation and general anaesthesia) but shall not, with a view to obtaining the agreement of a patient to undergo services privately:

- advise a patient that the services which are necessary in his case are not available from the contractor under the contract; or
- seek to mislead the patient about the quality of the services available under the contract.[1]

The GDC also make it a professional and ethical requirement not to mislead patients about the availability of treatment[2] and warn about not pressurising patients to accept private treatment that could be available on the NHS:

- 1.7 You must put patients' interests before your own or those of any colleague, business or organisation
- 1.7.3 You must not mislead patients into believing that treatments which are available on the NHS (or equivalent health service) can only be provided privately. If you work in a purely private practice, you should make sure that patients know this before they attend for treatment
- 1.7.4 If you work in a mixed practice, you must not pressurise patients into having private treatment if it is available to them under the NHS (or equivalent health service) and they would prefer to have it under the NHS (or equivalent health service).

And so we come to delivery of periodontal care by hygienists. From their training and experience and under their scope of practice they are the ideal members of the dental team to deliver this.

The business model operated by dental practice owners makes the provision of this service difficult to operate under the NHS since the hourly rate many hygienists command make it difficult to offer their services on the NHS. This is because most hygienists would like sufficient time to spend delivering their oral health messages, monitoring patient compliance and carrying out treatment. This is often a 30 minute appointment in which they have to carry out a range of hygiene services as well as infection control procedures before and after patients, unless they have the luxury of a dedicated nurse

So it seems it is difficult for practices to fund a hygienist on the NHS which is why the service is inevitably delivered under private contract.

And that is where the problems start especially when practice owners want the hygienists to be busy and for the service to be cost effective.

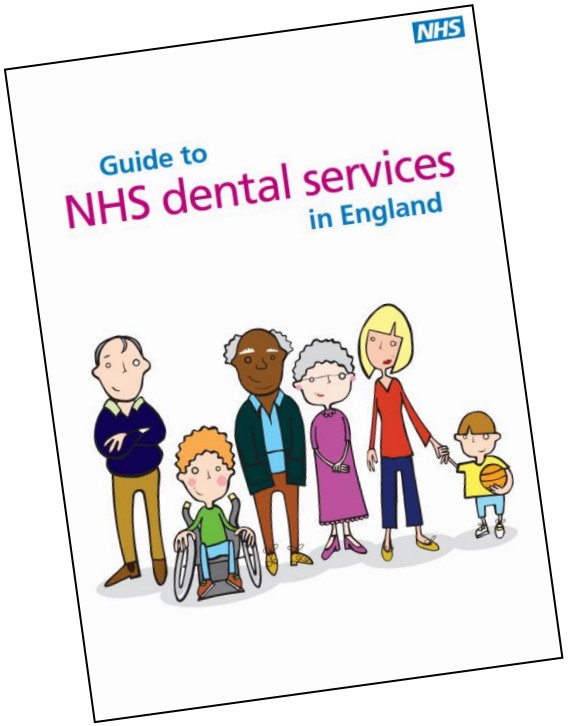
Associates are sometimes 'incentivised' to make the referrals by a small referral fee for each patient referred for treatment – fees of anything between £3 and £15 per patient.

Whilst this might on the face it appear a reasonable encouragement to associates to make a referral, the GDC has some concerns about the perceived ethics of this:

- 1.7.6 When you are referring patients to another member of the dental team, you must make sure that the referral is made in the patients' best interests rather than

BDJ in Practice June 2017


GDC
NHS



If your dentist says that you 'need' a particular type of treatment, it will be available under the NHS.

You should not be asked to pay privately for any treatment which is clinically necessary.

For example, if the dentist says that you need a scale and polish, this should be provided as part of your NHS course of treatment and you should not be asked to pay for it privately, or as a separate course of NHS treatment.

1.7.3 You must not mislead patients into believing that treatments which are available on the NHS(or equivalent health service) can only be provided privately. If you work in a purely private practice, you should make sure that patients know this before they attend for treatment.

1.7.4 If you work in a mixed practice, you must not pressurise patients into having private treatment if it is available to them under NHS and they would prefer to have it done under the NHS

HYGIENIST PRESCRIPTION

NHS Tasks Lock EXACT MPC

Hygienist Prescription

Diagnosis: Extent | Periodontitis | Stage (Severity) | Grade (Progression)

Stability: Currently Risk(s):

Please Provide the Following:

☐ Initial Therapy / Simple Scale ☐ Stain Removal ☐ Root Surface Debridement ☐ Maintenance

Other

☐ Leaflet Given ☐ Patient informed may initially be multiple visits as required followed by maintenance

Oral Hygiene Instruction

☑ Interdental Brushes ☑ Flossing ☐ Denture Hygiene

☑ TBI ☐ Dietary Advice ☐ Fluoride Application

Investigations

☐ Radiographs

☐ Plaque and Bleeding Scores ☑ Reconfirm BPE

☑ If BPE 4 any sextant - Full mouth 6ppc ☑ If BPE 3 - Initial Therapy followed by 6ppc if no improvement

Local Anaesthetic

Please Use LA As Appropriate: Up to 4 x 2.2ml 2% Lidocaine Hydrochloride wt 1/80000 Adrenaline - Infiltration/ID Block

Maintenance

☐ 3-4 Monthly ☐ 6 monthly ☐ Annual ☑ Hygienist to Decide

Specific area of concern / Other Information

Using BSP Jan 2019 Guidance

Internal Hygiene Referral - R Woodhoo Jan 2019 v5

OK Cancel

.C CROWNS - EXISTING

.CFG Full Gold Crown

WHAT DO I SAY TO A PATIENT WHEN REFERRING THEM TO SEE THE HYGIENIST ON A PRIVATE BASIS?

1.7.6 When you are referring patients to another member of the dental team, you must make sure that the referral is made in the patients' best interests rather than your own, or another team member's financial gain or benefit

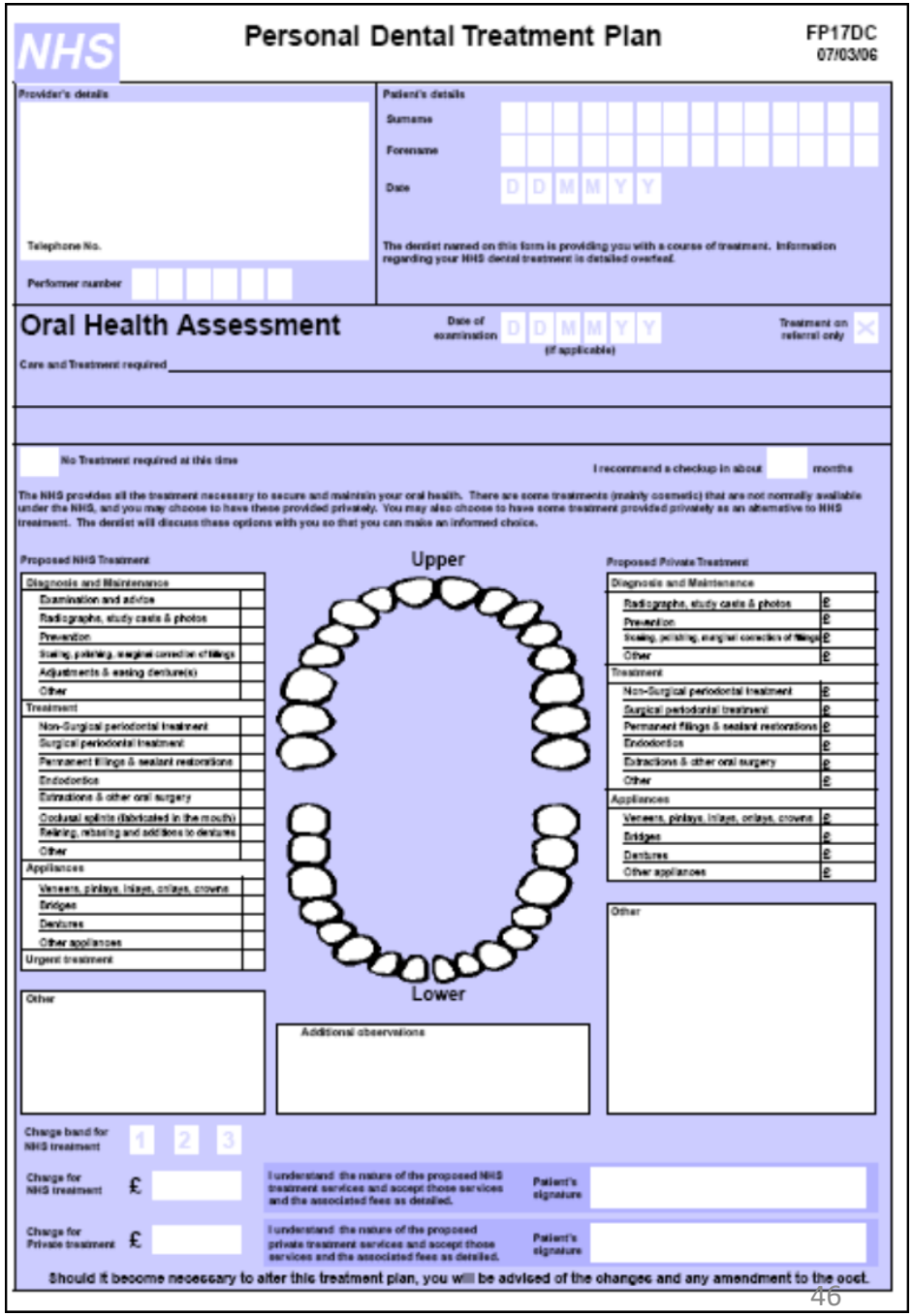
CDO UPDATE
Department of Health
DECEMBER 2009
A COMMUNICATION TO THE DENTAL TEAM FROM THE CHIEF DENTAL OFFICER

SCALE AND POLISH – CLARITY ON THE NHS/PRIVATE DEBATE

'You should not be asked to pay privately for any treatment which is clinically necessary. For example, if the dentist says that you need a scale and polish, this should be provided as part of your NHS course of treatment and you should not be asked to pay for it privately, or as a separate course of NHS treatment.'

If the practice uses the services of a hygienist, the practice may give the patient an option of seeing the hygienist privately. However, if the patient does not wish to have the treatment privately, then the practice is required to provide all necessary treatment on the NHS.

FP17DC TREATMENT PLAN



NHS

Personal Dental Treatment Plan

FP17DC
07/03/06

Provider's details

Telephone No.

Performer number

Patient's details

Surname

Forename

Date D D M M Y Y

The dentist named on this form is providing you with a course of treatment. Information regarding your NHS dental treatment is detailed overleaf.

Oral Health Assessment

Date of examination D D M M Y Y (if applicable)

Treatment on referral only

Care and Treatment required

No Treatment required at this time

I recommend a checkup in about months

The NHS provides all the treatment necessary to secure and maintain your oral health. There are some treatments (mainly cosmetic) that are not normally available under the NHS, and you may choose to have these provided privately. You may also choose to have some treatment provided privately as an alternative to NHS treatment. The dentist will discuss these options with you so that you can make an informed choice.

Proposed NHS Treatment

Diagnosis and Maintenance
- Examination and advice
- Radiographs, study casts & photos
- Prevention
- Scaling, polishing, surgical correction of fillings
- Adjustments & existing denture(s)
- Other

Treatment
- Non-Surgical periodontal treatment
- Surgical periodontal treatment
- Permanent fillings & sealant restorations
- Endodontics
- Extractions & other oral surgery
- Occlusal splints (fabricated in the mouth)
- Relining, rebasing and additions to dentures
- Other

Appliances
- Veneers, pinlays, inlays, onlays, crowns
- Bridges
- Dentures
- Other appliances

Urgent treatment

Upper

Lower

Proposed Private Treatment

Diagnosis and Maintenance
- Radiographs, study casts & photos £
- Prevention £
- Scaling, polishing, surgical correction of fillings £
- Other £

Treatment
- Non-Surgical periodontal treatment £
- Surgical periodontal treatment £
- Permanent fillings & sealant restorations £
- Endodontics £
- Extractions & other oral surgery £
- Other £

Appliances
- Veneers, pinlays, inlays, onlays, crowns £
- Bridges £
- Dentures £
- Other appliances £

Other

Other

Additional observations

Charge band for NHS treatment 1 2 3

Charge for NHS treatment £

I understand the nature of the proposed NHS treatment services and accept those services and the associated fees as detailed. Patient's signature

Charge for Private treatment £

I understand the nature of the proposed private treatment services and accept those services and the associated fees as detailed. Patient's signature

Should it become necessary to alter this treatment plan, you will be advised of the changes and any amendment to the cost.


Why perio claims are increasing
Clinical assessment
Record keeping
Referrals to hygienist and specialists
Managing periodontal patients on the NHS
BDA Indemnity

Claiming for Perio on the NHS

Q. Is periodontal treatment Band 1 or Band 2 treatment?

Band 1

PREVENTION

- Instruction in the prevention of dental and oral disease including dietary advice and dental hygiene
- Scaling,polishing and marginal corrections of fillings

Band 2

TREATMENT

- Non-surgical periodontal treatment including root planing, deep scaling, irrigation of periodontal pockets and subgingival curettage an dall necessary scaling and polishing
- Surgical periodontal treatment including gingevectomy, gingivoplasty or removal of operculum
- Surgical periodontal treatment including raising and replacement of muco-periosteal flaps, curretage,root planing and bone resection

The National Health Service (Dental Charges) Regulations 2005

Draft Legislation: This is a draft item of legislation. This draft has since been made as a UK Statutory Instrument: The National Health Service (Dental Charges) Regulations 2005 No. 3477

No time bars between courses of treatment

No stipulation on the number of visits

You provide what is clinically necessary

Evidenced based periodontal treatment pathways

ESTABLISH A PRACTICE PROTOCOL

'Healthy gums do matter': A case study of clinical leadership within primary dental care

D. Moore,*[1] S. Saleem,[2] E. Hawthorn,[3] R. Pealing,[4] M. Ashley[5] and C. Bridgman[6]

PRACTICE

IN BRIEF

- Raises awareness of the role of NHS England's Local Professional Networks (LPNs) as a forum for clinical leadership in dentistry across England.
- Provides an example of commissioners supporting the development and piloting of a practitioner-led Toolkit for the management and prevention of periodontal disease.

The Health and Social Care Act 2012 heralded wide reaching reforms intended to place clinicians at the heart of the health service. For NHS general dental practice, the conduits for this clinical leadership are the NHS England local professional networks. In Greater Manchester, the local professional network has developed and piloted a clinician led quality improvement project: 'Healthy Gums DO Matter, a Practitioner's Toolkit'. Used as a case study, the project highlighted the following facilitators to clinical leadership in dentistry: supportive environment; mentoring and transformational leadership; alignment of project goals with national policy; funding allowance; cross-boundary collaboration; determination; altruism; and support from wider academic and specialist colleagues. Barriers to clinical leadership identified were: the hierarchical nature of healthcare, territorialism and competing clinical commitments.

INTRODUCTION

Clinical leadership in general dental practice may usually be thought of as the skills required to provide effective patient care within a successful business. However, the reforms brought about by the Health and Social Care Act[1] were intended to bring clinical leadership 'out of the clinic'. The aim was to place clinicians at the heart of the health service; in commissioning, priority setting and cross boundary service redesign, recommended by many as a way of improving quality of services for patients.[2] In the 2008 NHS next stage review by Lord Darzi on improving quality in the NHS, it was stated that to raise standards, 'there must be a stronger role for clinical leadership and management throughout the NHS'.[3] Despite this, the focus on clinical leadership has been criticised by some as political rhetoric, bound up with the oft-repeated critique on managers in the NHS.[4,5]

It has been argued that the concept of clinical leadership is not clearly defined, with much uncertainty about how it will work in practice, or if clinicians are adequately prepared or inclined to take on clinical leadership (and perhaps more so, followership) roles.[6,7] To date, there has been little evidence of clinical leadership by general dental practitioners (GDPs) in service redesign and quality improvement projects. A problem with the existing literature on clinical leadership is the focus on the traits and qualities of leaders and the dyadic relationship they have with their followers, without paying attention to the wider organisational culture and context that might allow effective clinical leadership to flourish.[8,9]

AIM

This article will examine how the post-2013 NHS reforms relate to dental services and how the new structures have led to an innovative, clinically-led quality improvement project in Greater Manchester (GM): 'Healthy Gums DO Matter'. The project will be used to explore current facilitators and barriers to clinical leadership in primary care dental services.

BACKGROUND TO THE 'HEALTHY GUMS DO MATTER' PROJECT

In order to facilitate increasing clinical leadership, since April 2013 the majority of NHS services have been commissioned by Clinical Commissioning Groups (CCGs). CCGs are local bodies led by general medical practitioners, with technical contract support from NHS England. They are responsible for allocating around 60% of the NHS budget.[3] However, dental, pharmacy and optical services are outside the CCGs remit and are commissioned directly by NHS England, through their regional area teams.[10] Clinical leadership in these services operates through the local professional networks (LPNs), which are embedded within each area team.

The remit of the LPN is to 'provide clinical leadership and facilitate wider clinical engagement at grass roots'.[10] The LPN structure is flexible depending on local capacity and preference, but they share some key characteristics. They are a clinically-led commissioning advisory team, which provide opportunities for clinicians to be involved in service improvement and redesign. They usually contain GDPs, dental practice advisors, commissioners and consultants in dental public health, postgraduate deanery representatives and specialists.

In the summer of 2012 in GM, the local consultant in dental public health established and chaired a 'shadow LPN' in order to provide mentorship and facilitate empowerment of GDPs in preparation for the establishment of the LPN proper in 2013. The aim was to develop their skills and experience so that they might be in a position to take on leadership roles in the future commissioning landscape. The first project the shadow LPN worked on was 'Baby Teeth DO Matter'. Child oral health is a priority for GM, with a caries prevalence in five-year-olds of 41%, compared to 28% nationally.[11]

The 'Baby Teeth DO Matter' project encouraged practices to become community-facing, improve early dental attendance, deliver evidence-based prevention and liaise with local

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*British Dental Journal 2015; 219: 255–259

BDJ 2015;219:255-259

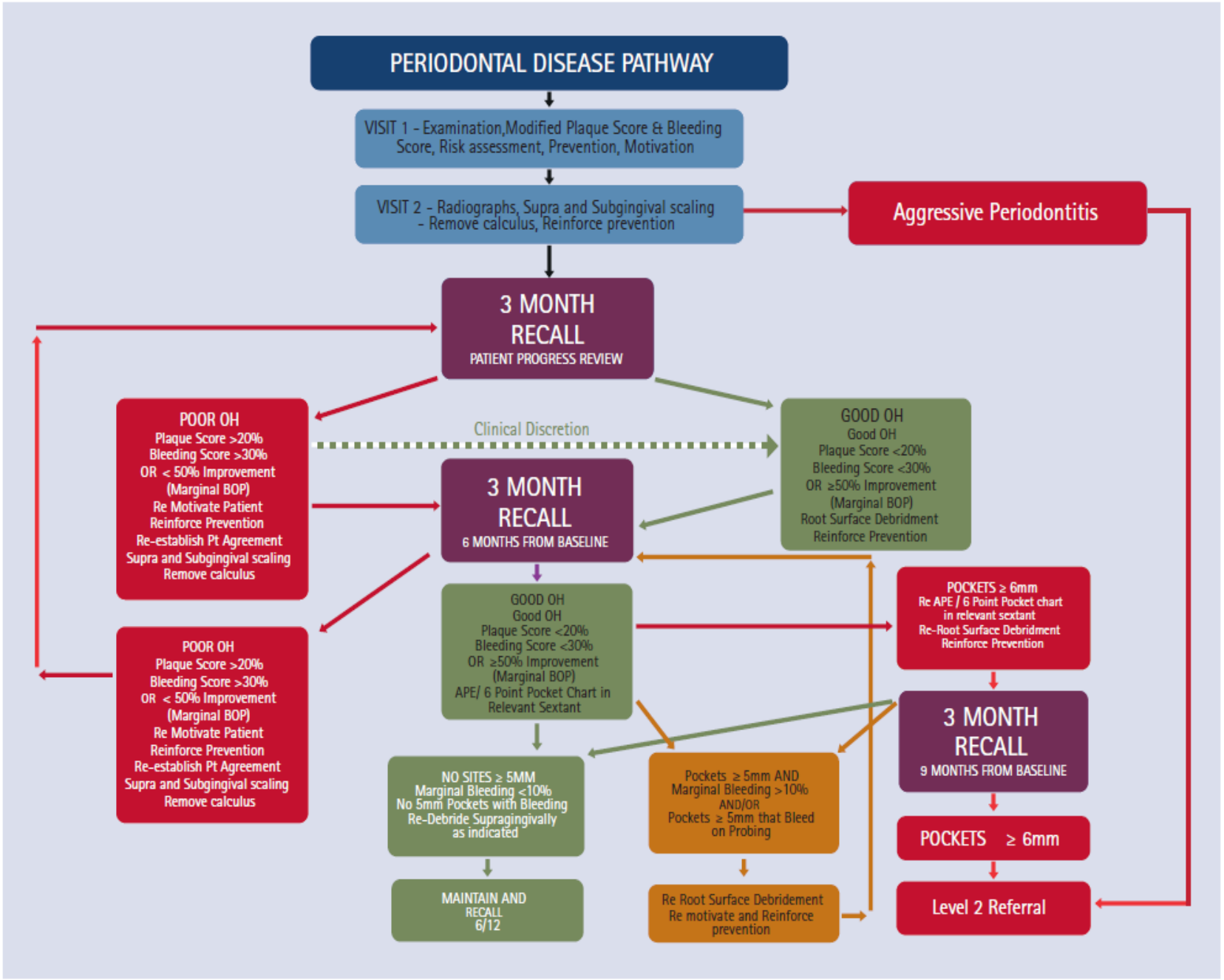

Fig. 1 Example of the care pathway to be followed by a patient identified as having disease (BPE scores of three).[23] A patient who engages with oral hygiene advice will follow the green section of the pathway. A non-engaging patient will follow the red section of the pathway

WHEN SHOULD I REASSESS THE PATIENT AFTER INITIAL TREATMENT

Factors affecting decision making at reassessment of periodontitis. Part 1: history and examination at reassessment

Amardip S. Kalsi,*[1] Deborah I. Bomfim[2] and Zahra Hussain[2]

Key points

- Points out that periodontal reassessment is distinct from initial assessment in that the patient's response to initial therapy will be apparent.
- Indicates that a thorough assessment should be taken to aid decision-making.
- Outlines the method of history and examination at reassessment.

Abstract

Periodontal therapy aims to arrest the disease while maintaining function and aesthetics. Reassessment allows an opportunity to assess the periodontal status and need for further treatment. This is distinct from initial assessment in that the patient's response to initial therapy will be apparent and many treatment options other than non-surgical therapy require consideration. This series of papers outlines the processes to undergo at periodontal reassessment in order to assess viable treatment options and decide on a plan. This first article focuses on the information that should be gathered at the reassessment appointment in order to allow a full view of a case to aid decision-making. Subsequent papers in this series discuss the systemic and local factors that can account for residual probing depths, assessment of prognosis and treatment planning. Reassessment should be undertaken in a detailed manner to establish the reasons for any residual periodontal probing depths which will lead to the appropriate treatment option.

History and examination at reassessment

When to reassess

Due to the progressive nature of periodontitis, the reassessment stage is important in order to assess patient compliance and the outcome of initial treatment, in addition to other factors that can affect disease progression or stabilisation. Patients should be made aware of the nature of periodontitis, including the risk of disease progression following a period of stability, and the subsequent need for ongoing re-evaluation.

Different timescales have been suggested regarding when to carry out the periodontal reassessment after initial therapy. The biggest changes in periodontal probing depths occur up to 3 months following initial therapy and healing at a slower pace occurs for up to 9 months.[6] In view of this, it has been suggested that reassessment should be carried out at 3 months. A shorter time period has been suggested of between 4 to 8 weeks; the authors' clinical practice involves reassessing at 6 to 8 weeks, for the reasons shown in

The biggest changes in periodontal probing depths occur up to 3 months following initial therapy and healing at a slower pace occurs for up to 9 months.

In view of this, it has been suggested that reassessment should be carried out at 3 months

NHS England

Avoidance of Doubt
Provision of Phased Treatments

Background

The purpose of this document is to support dental professionals, and to clarify where it might be appropriate to provide phased treatment spanning over several courses of treatment (CoT). In turn, this should improve access to high quality NHS dentistry to meet the needs of patients who will not usually have accessed and completed routine dental care in the previous 24 months. This cohort of patients would generally be those with high dental needs and as such are more likely to be adults from a vulnerable background with additional health or social needs.

Description of phases

Phased treatment may consist of up to three courses of treatment; all these CoTs will usually be completed within a 12 month period. It is acknowledged that often the first course is an initial assessment with pain relief, stabilisation of active disease and initiation of initial preventive measures where it is not possible to produce a robust plan for further treatment at the examination stage.

It is only after this first course has been completed and the patient reassessed to see how they have responded and a further treatment can be devised (CoT 2). In some cases a further reassessment and plan will be required (CoT 3).

At the very outset the patient should be made aware that they will be required to return for further courses of treatment, and that this may incur further NHS dental charges. It is not always possible to predict the exact nature and ,therefore, cost of the next phase until the reassessment course of treatment.

What needs to be documented in terms of phased treatment?

In CoT 1 the proposed treatment should be detailed with notes about the reasons for phasing into different CoTs. The patient should be made aware that the future CoT will be dependent on the reassessment at CoT 2 and so at this stage a detailed plan cannot be provided for the future CoTs. An appropriately completed FP17DC must be provided to the patient at each CoT. The impact on the patient charges must be explained to the patient and their understanding confirmed. The explanation for phasing treatment must be recorded in the notes. Clinical and patient factors should be considered carefully before advance care is provided.

Table 1. Example of documentation for phased treatment Course of Treatment (CoT 1)

CoT 1
Urgent treatment unless the patient wishes to have a full examination and treatment plan, and enter into the phased treatment pathway.
	• Examination (Band 1)
	• Risk assessment (Band 1)
	• Preventative advice (Band 1)
	• Periodontal assessment (Band 1)
	• Other appropriate treatment, such as
	  • dressing of carious lesions (Band 1 Urgent, or 2)
	  • removal of calculus (Band 1, 1 Urgent, or 2)
	  • pulp extirpation (Band 1 Urgent, or 2)
	  • extraction of teeth/tooth fragments (Band 1 Urgent, unless surgical extraction is required, then Band 2)

OCDO
OFFICE OF CHIEF DENTAL OFFICER ENGLAND

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www.england.nhs.uk

Phases

- Phased treatment may consist of up to 3 COTs

  All these will usually be completed with a 12 month period

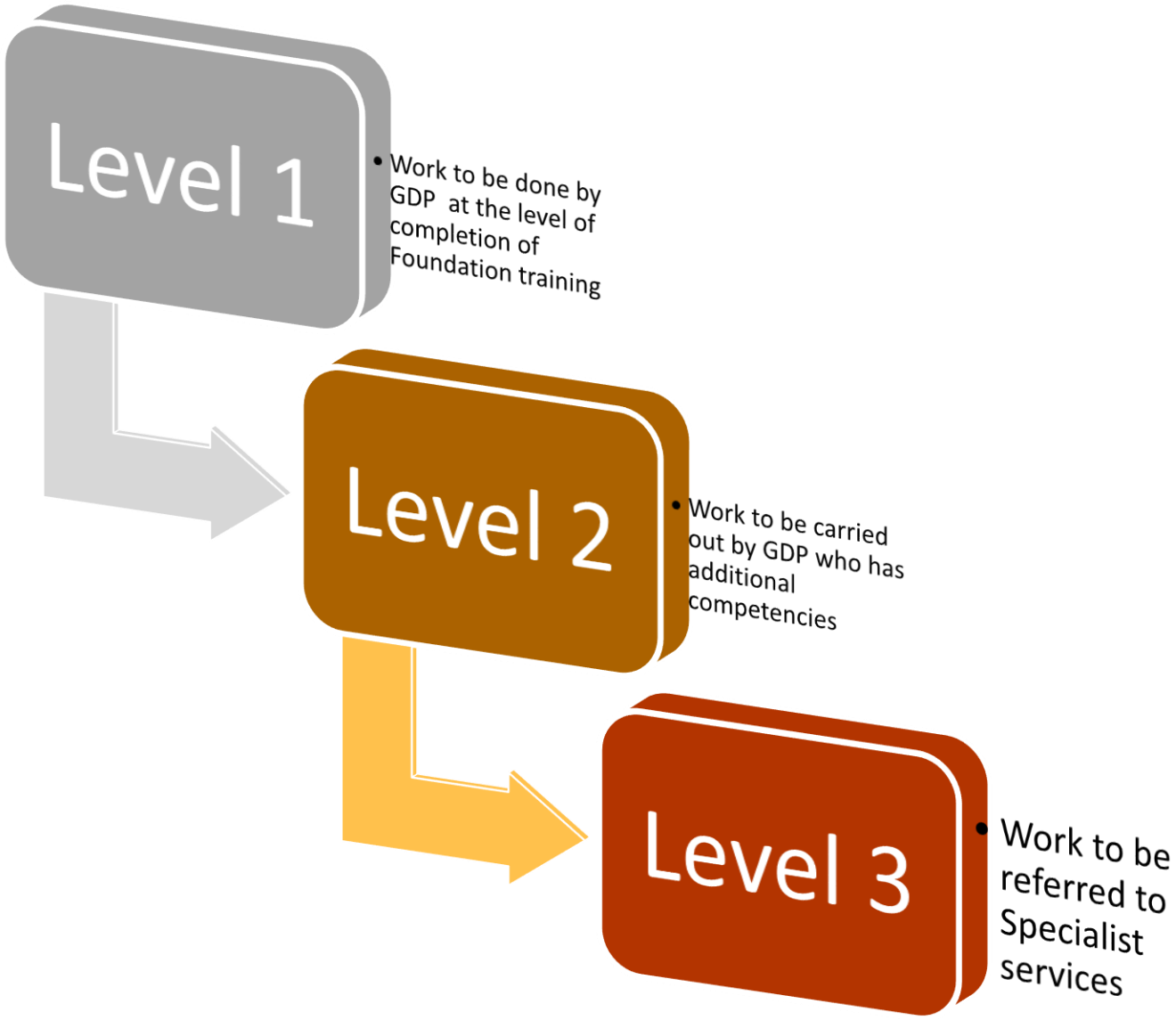
Charges

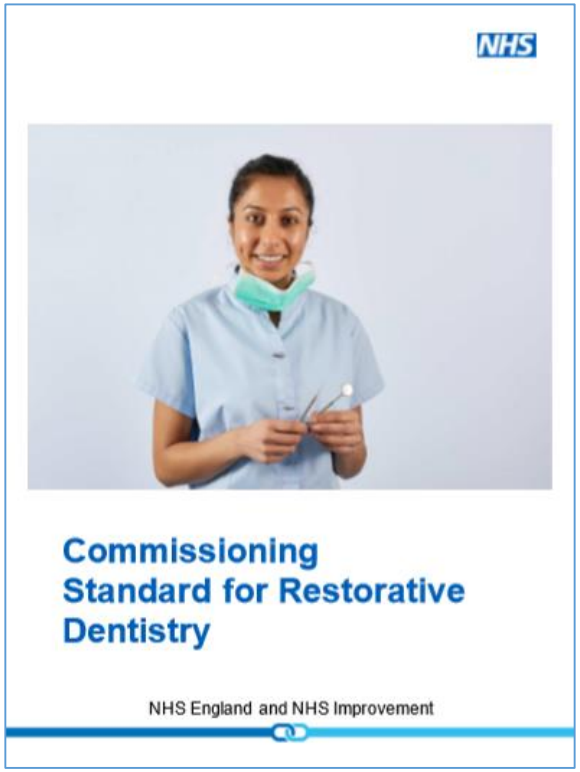
- Patient should be made aware of further NHS charges.
- Not always possible to predict exact nature until reassessment

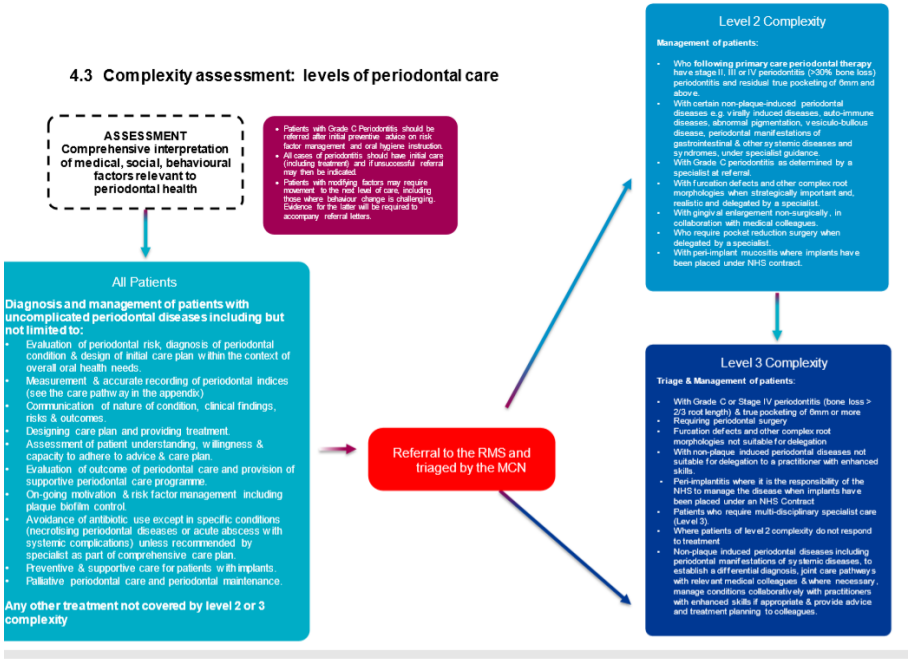
Records

- Issue FP17DC for each COT
- Explanation for phasing must be recorded in the notes
- Clinical and patient factors should be considered before advance care is provided

SKILL LEVELS- WHAT ARE GDP's EXPECTED TO DO?


Level 1
Work to be done by GDP at the level of completion of Foundation training
Level 2
Work to be carried out by GDP who has additional competencies
Level 3
Work to be referred to Specialist services





Published 4th July 2019

https://www.england.nhs.uk/publication/commissioning-standard-for-restorative-dentistry/

ASSESSMENT
Comprehensive interpretation of medical, social, behavioural factors relevant to periodontal health

- Patients with Grade C Periodontitis should be referred after initial preventive advice on risk factor management and oral hygiene instruction.
- All cases of periodontitis should have initial care (including treatment) and if unsuccessful referral may then be indicated.
- Patients with modifying factors may require movement to the next level of care, including those where behaviour change is challenging. Evidence for the latter will be required to accompany referral letters.

All Patients

Diagnosis and management of patients with uncomplicated periodontal diseases including but not limited to:

- Evaluation of periodontal risk, diagnosis of periodontal condition & design of initial care plan within the context of overall oral health needs.
- Measurement & accurate recording of periodontal indices (see the care pathway in the appendix)
- Communication of nature of condition, clinical findings, risks & outcomes.
- Designing care plan and providing treatment.
- Assessment of patient understanding, willingness & capacity to adhere to advice & care plan.
- Evaluation of outcome of periodontal care and provision of supportive periodontal care programme.
- On-going motivation & risk factor management including plaque biofilm control.
- Avoidance of antibiotic use except in specific conditions (necrotising periodontal diseases or acute abscess with systemic complications) unless recommended by specialist as part of comprehensive care plan.
- Preventive & supportive care for patients with implants.
- Palliative periodontal care and periodontal maintenance.

Any other treatment not covered by level 2 or 3 complexity

Level 2 Complexity

Management of patients:

- Who **following primary care periodontal therapy** have stage II, III or IV periodontitis (>30% bone loss) periodontitis and residual true pocketing of 6mm and above.
- With certain non-plaque-induced periodontal diseases e.g. virally induced diseases, auto-immune diseases, abnormal pigmentation, vesiculo-bullous disease, periodontal manifestations of gastrointestinal & other systemic diseases and syndromes, under specialist guidance.
- With Grade C periodontitis as determined by a specialist at referral.
- With furcation defects and other complex root morphologies when strategically important and, realistic and delegated by a specialist.
- With gingival enlargement non-surgically, in collaboration with medical colleagues.
- Who require pocket reduction surgery when delegated by a specialist.
- With peri-implant mucositis where implants have been placed under NHS contract.

Level 3 Complexity

Triage & Management of patients:

- With Grade C or Stage IV periodontitis (bone loss > 2/3 root length) & true pocketing of 6mm or more
- Requiring periodontal surgery
- Furcation defects and other complex root morphologies not suitable for delegation
- With non-plaque induced periodontal diseases not suitable for delegation to a practitioner with enhanced skills.
- Peri-implantitis where it is the responsibility of the NHS to manage the disease when implants have been placed under an NHS Contract
- Patients who require multi-disciplinary specialist care (Level 3).
- Where patients of level 2 complexity do not respond to treatment
- Non-plaque induced periodontal diseases including periodontal manifestations of systemic diseases, to establish a differential diagnosis, joint care pathways with relevant medical colleagues & where necessary, manage conditions collaboratively with practitioners with enhanced skills if appropriate & provide advice and treatment planning to colleagues.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Local Dental Network

Healthy gums DO matter!

Periodontal Management In Primary Dental Care
Greater Manchester Local Dental Network

Practitioner's Toolkit

Second Edition | Spring 2019

Periodontal Information Leaflet & Consent Form

You have been diagnosed with a destructive form of gum disease called "Periodontitis". Periodontitis causes irreversible destruction of the bone and tissues that hold the teeth in the jaw. The disease is usually slowly progressing, but it can go through periods of rapid destruction and in rare cases it can be very aggressive.

Now you have this condition you will need to make changes to your lifestyle and daily routines if you wish to keep your teeth. You will also require continuing close care and support to prevent it from getting worse and to detect any relapse. This will mean regular dental examination appointments, most likely every 3 months in the initial phase until the disease is stabilised.

The end result of periodontitis can be tooth mobility and eventual tooth loss. In most cases periodontitis is a painless, silent disease causing problems in the late stages, usually due to pain associated with tooth mobility and recurrent gum abscesses. Periodontitis is treatable and we can stabilise the disease, but this can only be done if we have your daily cooperation.

Some of the signs of periodontitis are:

- Bleeding gums
  Healthy Gums DO NOT Bleed
- Swollen and tender gums
- Bad breath
- Recession of the gums
- Tooth loss
- Sensitivity of the teeth
- Lengthening of the teeth
- Loose teeth
- Gum abscesses

Periodontitis can be halted and kept stable to prevent further destruction of the bone and tissues supporting the teeth. There are many risk factors for periodontitis, but the main risk factor is dental plaque. In order for periodontal treatment to be successful, it must be supported by very high standards of daily oral hygiene and home self-care.

oral hygiene at home, it will not be successful and the result will be continuing destruction of the bone supporting your teeth leading to increasing tooth mobility and eventual tooth loss.

The disease works in a very similar way to type 2 diabetes, and so just as a diabetes patient has to keep tight control of their diet and monitor their blood sugar levels,

If you are a smoker it negatively impacts upon how you heal and so periodontal treatment is less effective, and there is an increased risk of tooth loss.

Therefore, it is important that you stop smoking and using other oral tobacco and nicotine replacements in order for treatment to work well. If you would like some support to stop smoking, please speak with

Summary

- Adequate screening (BPE)
- A diagnosis and INFORMING THE PATIENT
- Reasonable standard of NSPT
- An assessment of the tx outcome
- A long term plan/long term care
- Referral if necessary
- Good standard of record keeping


Why perio claims are increasing
Clinical assessment
Record keeping
Referrals to hygienist and specialists
Managing periodontal patients on the NHS
BDA Indemnity


BDA
British Dental Association
GAP

SO YOU WANT TO CHANGE YOUR INDEMNITY PROVIDER?


BEFORE YOU CHANGE……..

Claims made

V

occurrence based

Contractual

V

Discretionary

Dentists for dentists

Claims made

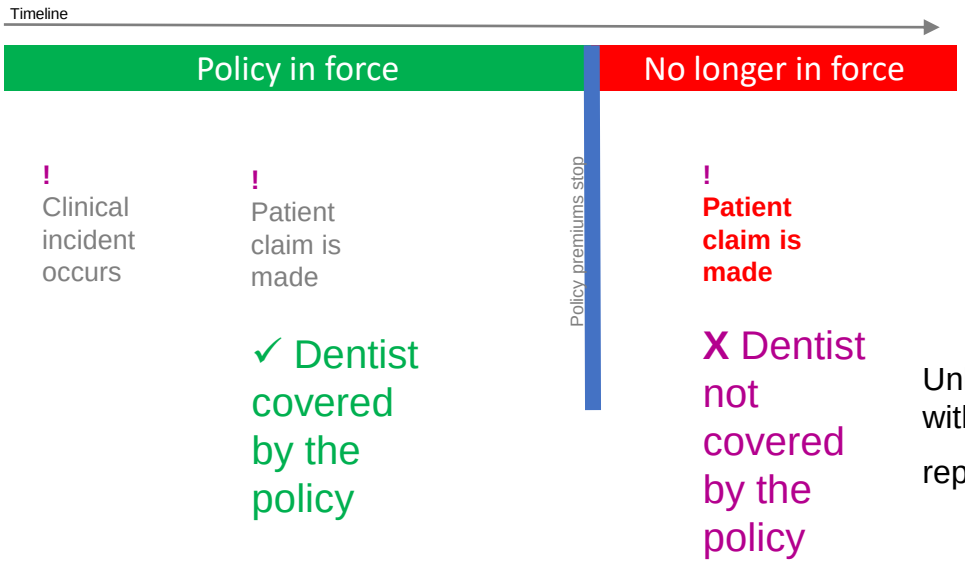
V

occurrence based

Claims made

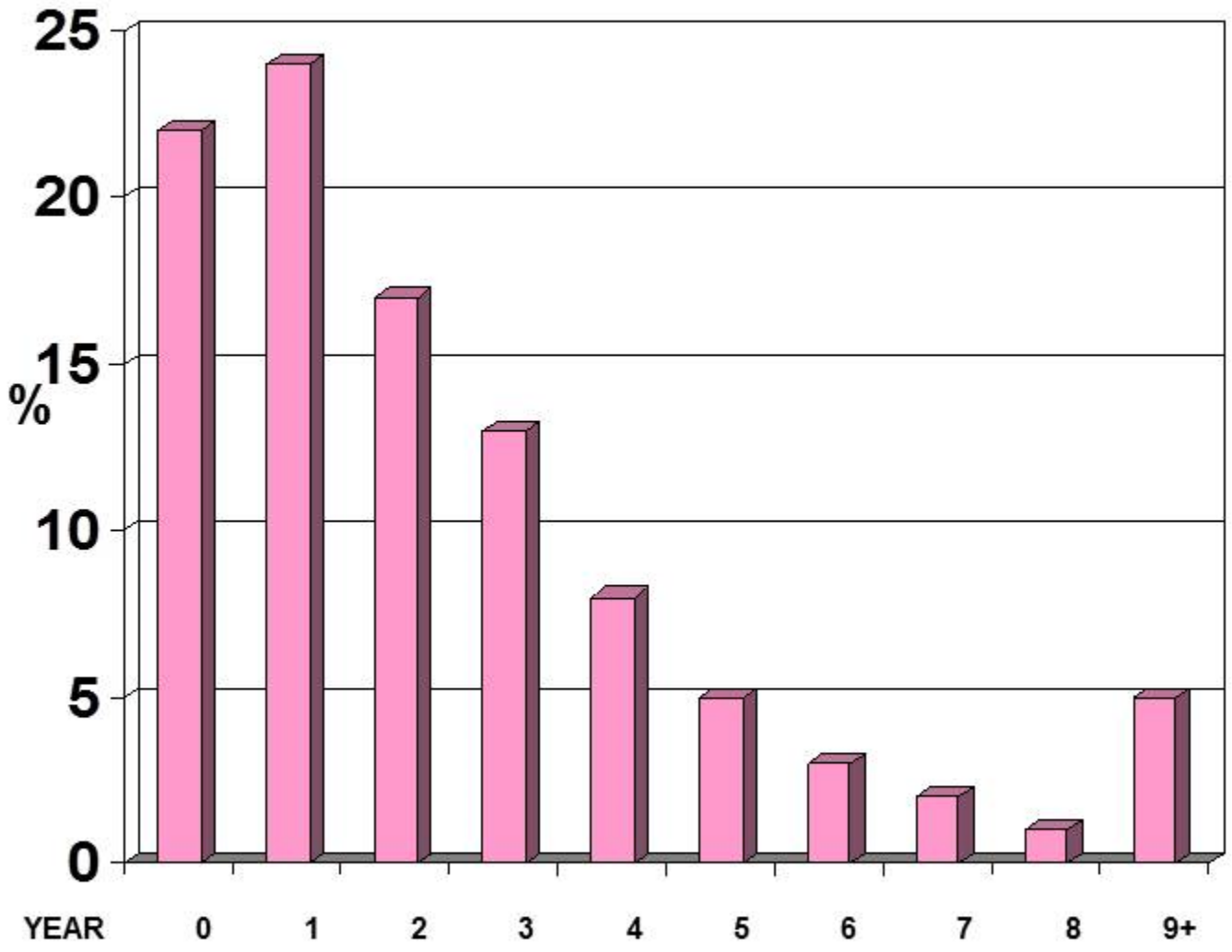
- As long as you are paying the premiums you will be covered when the claim is made by the patient
- Many claims come in 2-5 years after the actual incident
- If you are not paying the premiums because you have left the insurer, retired, on maternity leave or long term sick leave you may have to pay “run off cover”

Claims-made policy



Unless the claim is made within an agreed extended reporting period (run-off).

Estimated percentage of total dental cases reported year-on-year



ELAPSED YEARS FOLLOWING INCIDENT DATE (YEAR 0 = YEAR OF TREATMENT / INCIDENT)

Claims made
V
occurrence based

Claims made

- As long as you are paying the premiums you will be covered when the claim is made by the patient
- Many claims come in 2-5 years after the actual incident
- If you are not paying the premiums because you have left the insurer, retired, on maternity leave or long term sick leave you will have to pay “run off cover”

Occurrence based

- As long as you were paying the premiums at the time you were treating the patient and in the right subscription category you will be covered without having to pay “run off cover”

Contractual
V
Discretionary

Contractual

- If it is in the contract the insurance company is legally obliged to cover you under the terms of the contract
- Overseen by the Financial Ombudsman
- Regulated by the Financial Conduct Authority

Discretionary

- The company (usual a mutual) has the ultimate discretion whether they will assist you with a claim, complaint or GDC case
- There is no contractual obligation they have with you
- May be able to exercise their discretion to assist beyond what a contract might have covered

Dentists for dentists

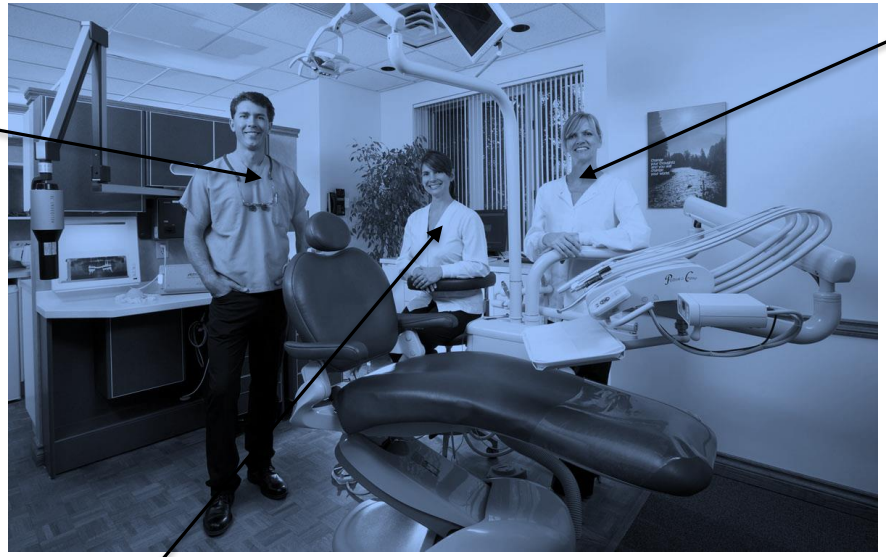
- Do they cover dentists only or do they cover doctors (and surgeons and obstetricians and gynaecologists etc) ?
- Do they have a dento- legal advisers you can speak to when you call or is it handled by a non-dentist ?
- Do they have risk management education, publications and training?

Vicarious liability, sometimes referred to as “imputed liability,” and the the Latin term *“respondeat superior,”* is a legal concept that assigns liability to an individual who did not actually cause the harm, but who has a specific superior legal relationship to the person who did cause the harm.

VICARIOUS LIABILITY

Who is the practice owner responsible for?

Associate dentist ?



Receptionist ?

Nurse?

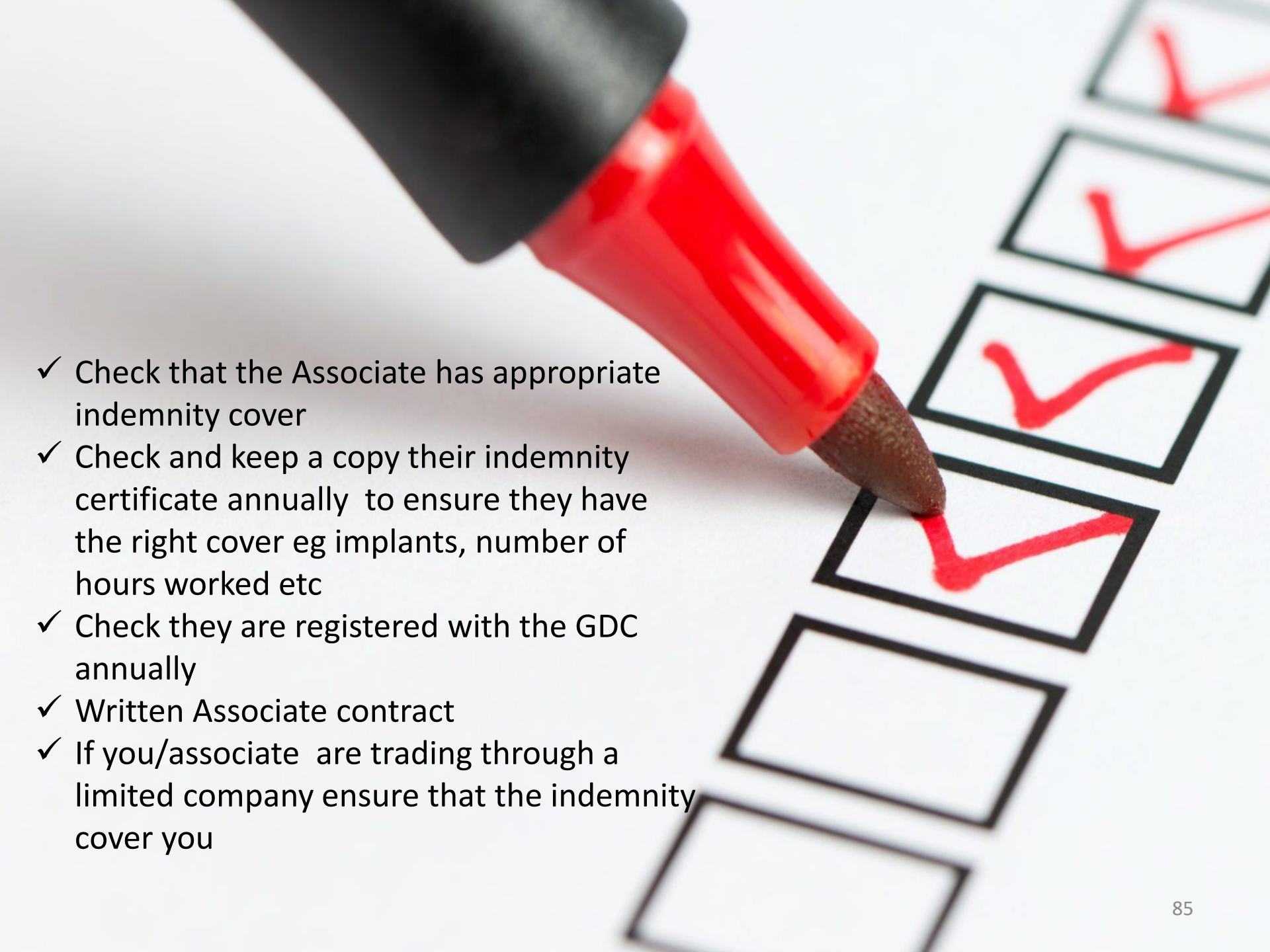
Dear Mr Dentist

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

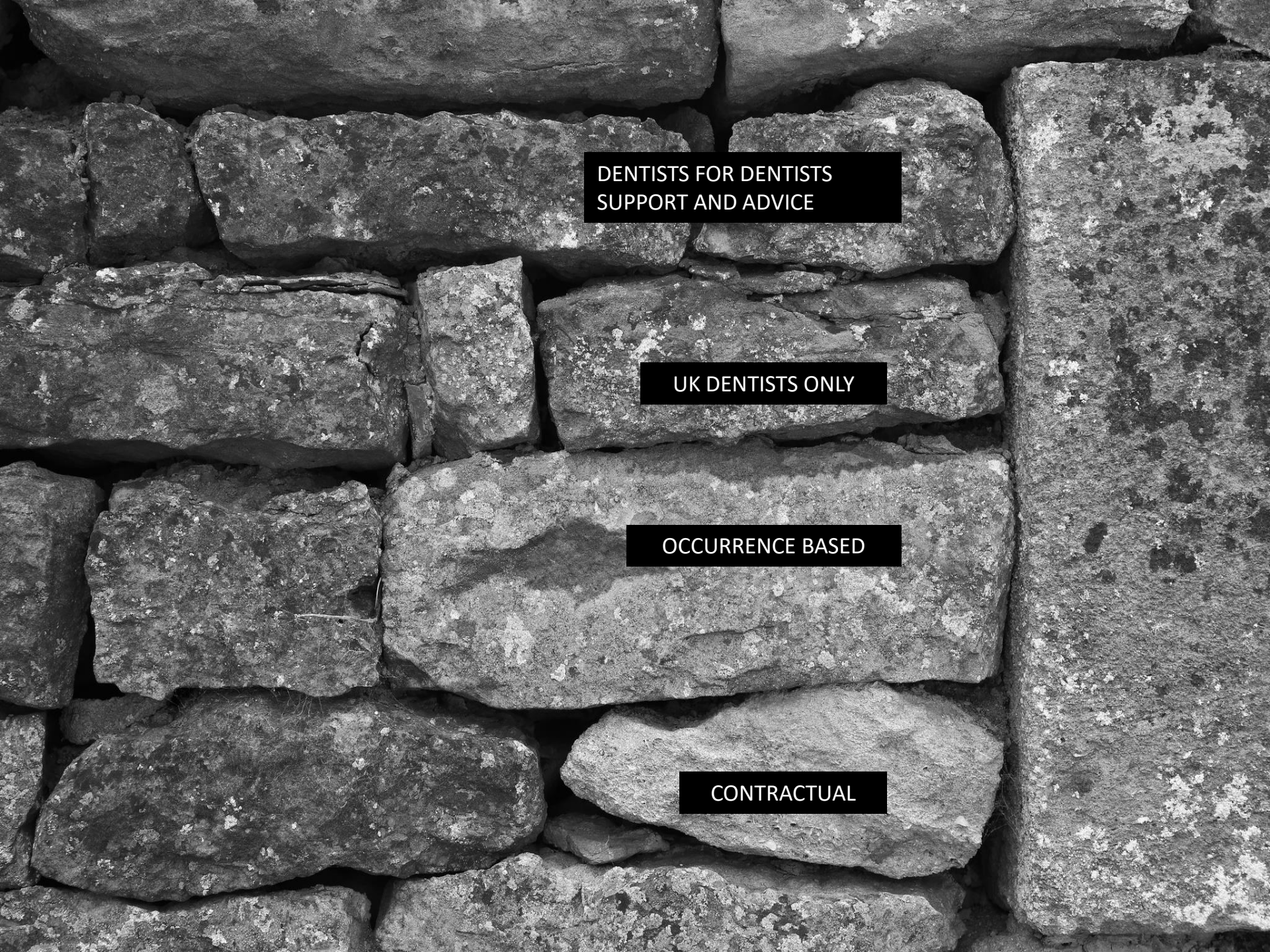
we sue dentists. com

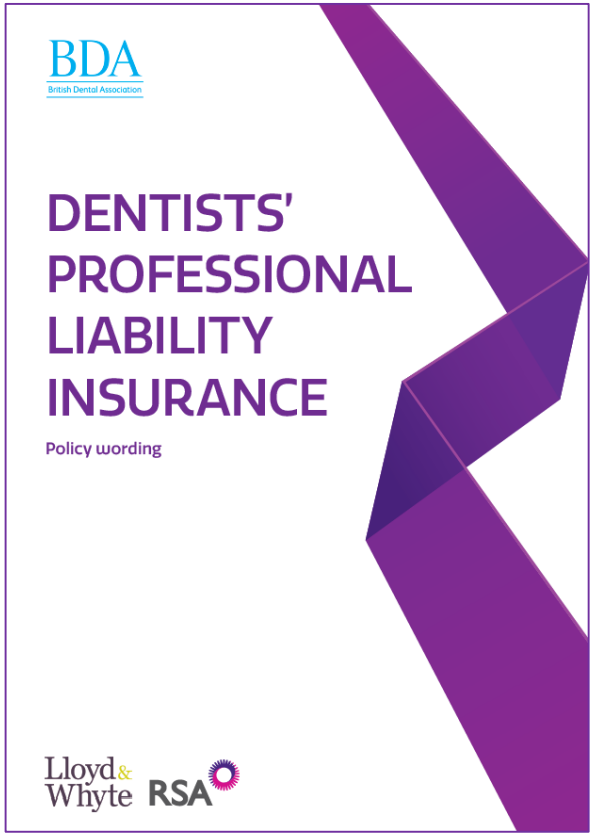


- ✓ Check that the Associate has appropriate indemnity cover
- ✓ Check and keep a copy their indemnity certificate annually to ensure they have the right cover eg implants, number of hours worked etc
- ✓ Check they are registered with the GDC annually
- ✓ Written Associate contract
- ✓ If you/associate are trading through a limited company ensure that the indemnity cover you

The Product


A of some of the ways to Z we can help you
A is for Advice
Our website has a wealth of advice and we have a te
ready to offer free one-to-one advice for Extra and E
bda.org/advice
A of some of the ways to Z we can help you
L is for Legal
Our team of 28 expert advisers and lawyers are on h
support members. We'll support you with a wide ran
your working life.
bda.org/advice
BDA
British Dental Association
DENTISTS' PROFESSIONAL LIABILITY INSURANCE
Policy wording
Lloyd & Whyte
RSA


DENTISTS FOR DENTISTS
SUPPORT AND ADVICE
UK DENTISTS ONLY
OCCURRENCE BASED
CONTRACTUAL


BDA
British Dental Association
DENTISTS' PROFESSIONAL LIABILITY INSURANCE
Policy wording
Lloyd & Whyte
RSA

BDA Indemnity
British Dental Association

Lloyd & Whyte

RSA

temple
legal protection

Civil liability in public and product liability claims
Cover for damages where appropriate

Defence costs regarding civil liability claims
Cover for all legal costs including experts' fees

Legal representation
We'll fight your corner and pay expert fees in investigations and inquiries, hearings (inc GDC and disciplinary), tribunals, courts (inc inquests)

Crisis management
You'll have lawyers and/or expert media consultants on hand in the event of a professional crisis, and those costs are covered

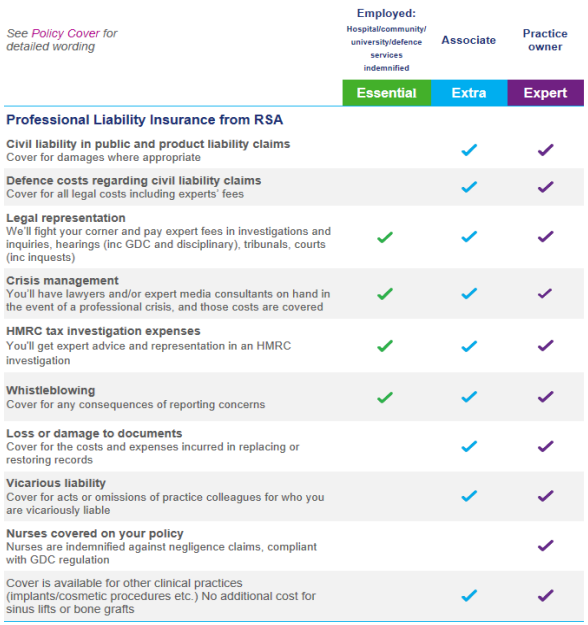
HMRC tax investigation expenses

Whistleblowing
Cover for any consequences of reporting concerns

Vicarious liability
Cover for acts or omissions of practice colleagues for who you are vicariously liable

Nurses covered on your policy
Nurses are indemnified against negligence claims, compliant with GDC regulation

Cover is available for other clinical practices (implants/cosmetic procedures etc.)
No additional cost for sinus lifts or bone grafts



See Policy Cover for detailed wording	Employed: Hospital/community/university/defence services indemnified	Associate	Practice owner
	Essential	Extra	Expert
Professional Liability Insurance from RSA			
Civil liability in public and product liability claims Cover for damages where appropriate		✓	✓
Defence costs regarding civil liability claims Cover for all legal costs including experts' fees		✓	✓
Legal representation We'll fight your corner and pay expert fees in investigations and inquiries, hearings (inc GDC and disciplinary), tribunals, courts (inc inquests)	✓	✓	✓
Crisis management You'll have lawyers and/or expert media consultants on hand in the event of a professional crisis, and those costs are covered	✓	✓	✓
HMRC tax investigation expenses You'll get expert advice and representation in an HMRC investigation	✓	✓	✓
Whistleblowing Cover for any consequences of reporting concerns	✓	✓	✓
Loss or damage to documents Cover for the costs and expenses incurred in replacing or restoring records		✓	✓
Vicarious liability Cover for acts or omissions of practice colleagues for who you are vicariously liable		✓	✓
Nurses covered on your policy Nurses are indemnified against negligence claims, compliant with GDC regulation			✓
Cover is available for other clinical practices (implants/cosmetic procedures etc.) No additional cost for sinus lifts or bone grafts		✓	✓

Civil liability in public and product liability claims
Cover for damages where appropriate

Defence costs regarding civil liability claims
Cover for all legal costs including experts' fees

Legal representation
We'll fight your corner and pay expert fees in investigations and inquiries, hearings (inc GDC and disciplinary), tribunals, courts (inc inquests)

Crisis management
You'll have lawyers and/or expert media consultants on hand in the event of a professional crisis, and those costs are covered

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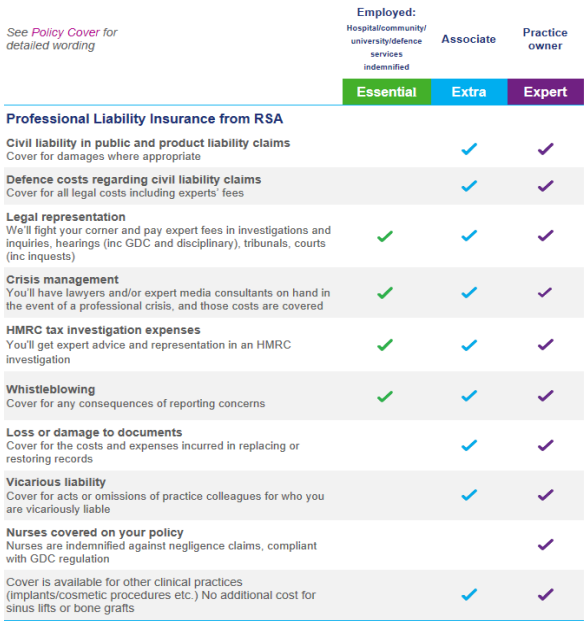

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Case management and dento-legal advice

Support with professional disputes
We'll assist if a colleague has criticised your work

NHS contract and performance disputes
We will help with any disputes and investigations

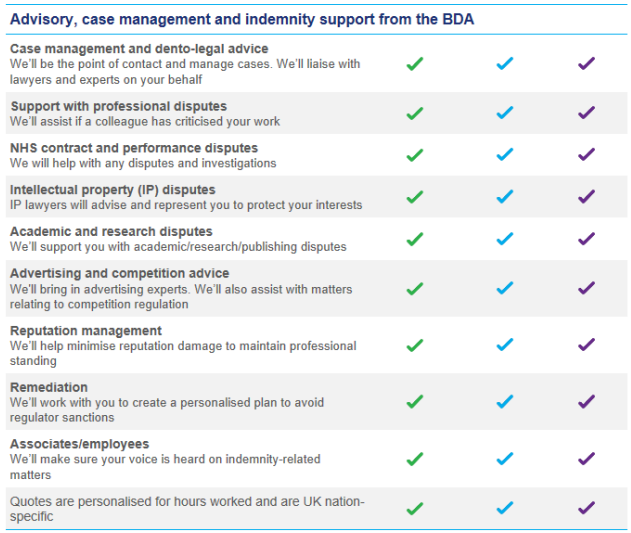
Intellectual property (IP) disputes
IP lawyers will advise and represent you to protect your interests

Academic and research disputes

Advertising and competition advice
We'll bring in advertising experts. We'll also assist with matters relating to competition regulation

Reputation management
We'll help minimise reputation damage to maintain professional standing

Remediation
We'll work with you to create a personalised plan to avoid regulator sanctions



Advisory, case management and indemnity support from the BDA			
Case management and dento-legal advice We'll be the point of contact and manage cases. We'll liaise with lawyers and experts on your behalf	✓	✓	✓
Support with professional disputes We'll assist if a colleague has criticised your work	✓	✓	✓
NHS contract and performance disputes We will help with any disputes and investigations	✓	✓	✓
Intellectual property (IP) disputes IP lawyers will advise and represent you to protect your interests	✓	✓	✓
Academic and research disputes We'll support you with academic/research/publishing disputes	✓	✓	✓
Advertising and competition advice We'll bring in advertising experts. We'll also assist with matters relating to competition regulation	✓	✓	✓
Reputation management We'll help minimise reputation damage to maintain professional standing	✓	✓	✓
Remediation We'll work with you to create a personalised plan to avoid regulator sanctions	✓	✓	✓
Associates/employees We'll make sure your voice is heard on indemnity-related matters	✓	✓	✓
Quotes are personalised for hours worked and are UK nation-specific	✓	✓	✓

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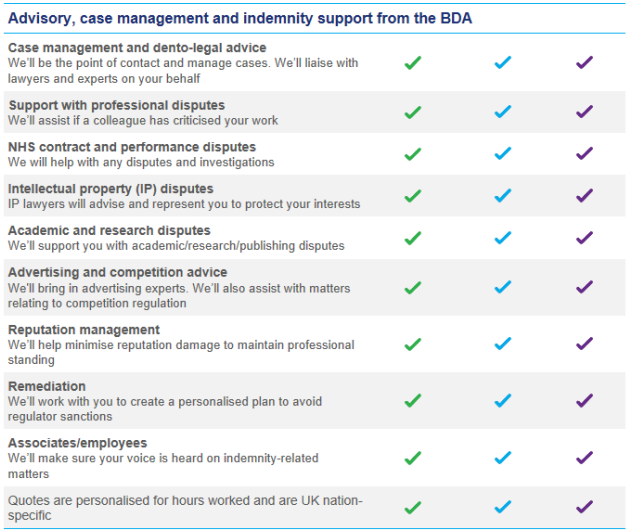

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Our offer to you…

BDA British Dental Association Indemnity

- We won't settle a claim without seeking the members' agreement
- We won't just give in to pressure to settle and make cases go away: we'll do what's right in each and every case
- There's no limit on how often members can call for help and calling won't penalise premiums
- It's a fair, inclusive and bespoke policy for the practice of dentistry.

Experts

Len D’Cruz

Senior Dento-legal Advisor

Lynn Stephens

Dento-legal Advisor

Russell Heathcote-Curtis

Dento-legal Advisor

Lorna Ead

Dento-legal Advisor

Jane Merivale

Dnto-legal advisor

The Process

On line quote

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We've been by your side since 1880 and continue to support you with every step of your professional journey.

Members can now choose indemnity cover through us.

Get an indicative quote

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

How much will it cost?

Key features and benefits

BDA British Dental Association Indemnity

- Occurrence-based (in perpetuity) for long-term peace of mind
- Contractual: a legally-binding right to cover
- Top 5 UK insurer-backed policy* with assured financial security
- Dentist-led advice and case management respecting members'
- unique situations
- Flexible category structure so members only pay for what they do, so they're not subsidising the risks of other dentists or medical colleagues**

* Standard & Poor's credit rating 20 June 2018
** Subject to policy terms and conditions


ASK
THE RIGHT
QUESTIONS

Ask the insurance companies

Why claims made not occurrence based ?
How many years run off cover do I get ?
Will that be enough?
How much will it cost me to get more years cover?
Can I be sure that you will offer me run off cover or is that provided on a discretionary basis?

Ask the mutuals

If a claim is made against me a few years after I retire will you guarantee to cover me ?

Can you give me an example of when you have exercised your discretion to cover a member when an insurance policy from another provider would not have covered them ?

ASK THEM ALL

Have they got the expertise to advise you on

- NHS disputes with the commissioners
- Employment matters
- Provide detailed compliance support for practice inspections from regulators like CQC, RQIA, HIW
- Business matters


TRUST

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

THANK YOU

lendcruz1@gmail.com

BDA British Dental Association Indemnity

Registered office 64 Wimpole Street London W1G 8YS. Limited by guarantee (14161) England. 020 7935 0875 | enquiries@bda.org | bda.org

The policy is arranged by the British Dental Association and underwritten by Royal & Sun Alliance.
The British Dental Association is an appointed representative of Lloyd & Whyte Ltd.
Lloyd & Whyte Ltd is authorised and regulated by the Financial Conduct Authority (FCA).
The FCA does not regulate the advice you receive with regards to Advisory, Case Management and Indemnity Support provided by the BDA.

Calls are recorded for training and monitoring purposes.