Indemnity

A unique service designed for dentists and dentistry

Exclusive to BDA members

bda.org/indemnity
BDA Indemnity

We’ve been by your side since 1880 and we’re still creating new ways to support you.

Using the knowledge, expertise and experience that only we have, we’ve created an indemnity service designed around you.

BDA Indemnity represents a new, vital component of our service providing you with a professional shield against legal and regulatory challenges. We designed it to make sure you’re equipped to thrive in today’s professional environment.

This new offer, combined with our vast knowledge base, provides a powerful resource to protect and support you.

It includes robust, reliable and accessible professional liability insurance, plus dentist-led advice and resources. Because the policy is occurrence-based, you can have complete, comprehensive and secure protection stretching far into the future: you’re covered forever for treatments performed during the policy term.

This is something you haven’t come across before - it’s unique to dentistry.

And to make sure it’s accessible, we’ve worked hard to price it fairly.

As a BDA member and policyholder, you will get:

**Peace of mind**
A contractual right to cover under the policy. You’ll have peace of mind that when an incident occurs under the policy, you’re covered forever. We state what is covered and what isn’t, so there’s no uncertainty.

**Dentist-to-dentist support**
You deserve support from experienced dentists with legal knowledge, in times of pressure. We’re here to help.

**Flexible cover**
Your cover needs to be just as flexible as the way you work, where you work, and what you do.

Policy highlights:

- Comprehensive professional indemnity for damages and legal costs
- Cover for vicarious liability
- Defence costs including GDC
- HMRC cover
- Cover for nurses
- Botox, whitening and fillers cover
- Reputation crisis management.

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.
What to expect

No matter what, in every case we’ll make sure that:

☐ We won’t settle a claim without seeking your 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 speak to our Indemnity Team, and calling won’t penalise premiums
☐ It’s a bespoke policy and service, designed with fairness at its heart, to protect you from the wide-ranging issues you may face.

Our service is unique

You’ll get all the benefits of being a BDA member, plus holistic personalised cover, including:

• Advice from experienced dentists, and case management that respects your unique situation
• A policy that’s backed by Royal and Sun Alliance Insurance plc, one of the UK’s top 5 UK insurers*, with assured financial security
• Long-term peace of mind, with occurrence-based (in perpetuity) cover
• A legally-binding right to cover, that underpins our contract with you **
• A flexible category structure so you only pay for what you do. That means you won’t be subsidising the risks of other dentists or medical colleagues, or peers in other countries.

Key facts can be found at bda.org/indemnity

For more information on the policy cover including significant limitations and exclusions, please visit bda.org/indemnity

*Standard & Poor’s credit rating 20 June 2018
** Subject to policy terms and conditions
Choosing your indemnity cover

Choosing your professional indemnity arrangement is one of the most important decisions you will make in your professional life. In fact, it could make the difference between continuing to practice as a dentist, or not.

The importance of time

If a patient complains, it’ll usually happen a while after their treatment. In fact, half of all claims take three or more years to come to light and many take much longer than that.

This means your cover has to protect you long into the future. Not all indemnity policies are the same, so you need to understand the benefits and limitations of your policy.

Imagine you started your BDA Indemnity cover today, then treated a patient. If that patient filed a complaint against you 5, 10, or 25+ years later – our policy would still cover it with no further additional payments because most complaints are managed by the BDA, not covered by the policy.

Types of indemnity cover

### Occurrence-based cover

<table>
<thead>
<tr>
<th>Occurrence-based cover</th>
<th>POLICY PREMIUMS STOP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy in force</td>
<td>Policy no longer in force</td>
</tr>
<tr>
<td><strong>Clinical incident occurs</strong></td>
<td><strong>Claim is made by patient</strong></td>
</tr>
<tr>
<td><img src="image" alt="Dentist covered by the policy" /></td>
<td><img src="image" alt="Dentist covered by the policy" /></td>
</tr>
</tbody>
</table>

*this is subject to the policy being in force when the patient received treatment

### Claims-made policies

<table>
<thead>
<tr>
<th>Claims-made policies</th>
<th>POLICY PREMIUMS STOP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy in force</strong></td>
<td><strong>Policy no longer in force</strong></td>
</tr>
<tr>
<td><strong>Clinical incident occurs</strong></td>
<td><strong>Claim is made by patient</strong></td>
</tr>
<tr>
<td><img src="image" alt="Dentist covered by the policy" /></td>
<td><img src="image" alt="Dentist not covered by the policy" /></td>
</tr>
</tbody>
</table>

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

### Occurrence-based cover

Occurrence-based cover provides perpetual indemnity for all treatments you perform within that policy period.

If an incident took place during the policy period (even on the last day), you’ll be covered - it doesn’t matter when the claim is made against you.

A single subscription for each year you practise protects you and your patients, forever.

The BDA Indemnity policy is occurrence-based, which is widely recognised as being the gold standard.

### Claims-made policies

The typical claims-made policy provides indemnity for incidents that arise out of treatments provided within the period of insurance, and that are also notified within the period of insurance. Less than 50% of claims are made within two years of the treatment being provided, so if you were to leave a claims-made policy or cease practising in the UK for any reason, you could find yourself without cover when you become aware of the claim years later.

These policies are designed to cover only a proportion of the claims that might arise within a given year, so can appear cheaper than occurrence-based policies at first glance. Those ceasing a claims-made policy may be offered the opportunity to purchase additional cover that will allow them to continue to be covered for the treatment provided during the period of insurance (referred to as run-off cover), however this comes at additional cost and is often only offered one year at a time.

---

1. Implementing Compulsory Indemnity: exploring the practical issues. Consultation response to Standards Committee of GDC, Dental Protection, 2005

---

Get an indicative quote at: bda.org/indemnity
# Indemnity cover: the features

- Dentist-led advice and case management respecting your unique situation
- Backed by Royal & Sun Alliance Insurance plc, with assured financial security
- Occurrence-based (in perpetuity) for long-term peace of mind
- Contractual: a legally-binding right to cover
- Flexible category structure so you only pay for what you do*

## Professional Liability Insurance from RSA

<table>
<thead>
<tr>
<th>Feature</th>
<th>Employed: hospital/community/university/defence services-indemnified</th>
<th>Associate</th>
<th>Practice owner</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Civil liability in public and product liability claims</strong></td>
<td>Cover for damages where appropriate</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Defence costs regarding clinical negligence claims</strong></td>
<td>Cover for all legal costs including experts’ fees</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Legal representation</strong></td>
<td>Well fight your corner and pay expert fees in investigations and inquiries, hearings (inc GDC and disciplinary), tribunals, courts (inc inquests)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Crisis management</strong></td>
<td>Lawyers and/or expert media consultants are on hand in the event of a professional crisis, and those costs covered</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>HMRC tax investigation expenses</strong></td>
<td>Get expert advice and representation in an HMRC investigation</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Whistleblowing</strong></td>
<td>Cover for any consequences of reporting concerns</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Loss or damage to documents</strong></td>
<td>Cover for the costs and expenses incurred in replacing or restoring records</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Vicarious liability</strong></td>
<td>Cover for acts of omissions of practice colleagues for whom you are vicariously liable</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Nurses covered on your policy</strong></td>
<td>Nurses are indemnified against negligence claims, compliant with GDC regulation</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Cover is also available for other clinical practices such as implants. No additional cost for sinus lifts or bone grafts.

- Cover is available for cosmetic procedures within the peri-oral area

## Advisory, case management and indemnity support from the BDA

<table>
<thead>
<tr>
<th>Feature</th>
<th>Employed: hospital/community/university/defence services-indemnified</th>
<th>Associate</th>
<th>Practice owner</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case management and dento-legal advice</strong></td>
<td>We’ll be the point of contact and manage cases. We’ll liaise with lawyers and experts on your behalf</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Support with professional disputes</strong></td>
<td>We’ll assist if a colleague has criticised your work</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>NHS contract and performance disputes</strong></td>
<td>We will help with any disputes and investigations</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Intellectual property (IP) disputes</strong></td>
<td>Intellectual property lawyers will advise and represent you to protect your interests</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Academic and research disputes</strong></td>
<td>We’ll support you with academic/research/publishing disputes</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Advertising and competition advice</strong></td>
<td>We’ll bring in advertising experts and also assist with matters relating to competition regulation</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Reputation management</strong></td>
<td>We’ll help minimise reputation damage to maintain professional standing</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Remediation</strong></td>
<td>We’ll work with you to create a personalised plan to avoid regulator sanctions</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Associates/employees</strong></td>
<td>We’ll make sure your voice is heard on indemnity-related matters</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Quotes are personalised for hours worked and are UK nation-specific

See About the policy for details bda.org/indemnity/policy

* Subject to policy terms and conditions
Eligibility for cover

If you’re a BDA member and a registered dentist working in the UK, then you’re eligible to apply for our indemnity cover.

Your employment status

Your work status must correlate with the following membership tiers:

<table>
<thead>
<tr>
<th>Members that are:</th>
<th>Must have the following BDA membership level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>Essential</td>
</tr>
<tr>
<td>Members who are exclusively hospital/community/university/defence service-employed</td>
<td></td>
</tr>
<tr>
<td>Associates</td>
<td>Extra</td>
</tr>
<tr>
<td>Members who are self-employed and engaged to provide treatment to patients but do not own a stake in a practice</td>
<td></td>
</tr>
<tr>
<td>Practice owners</td>
<td>Expert</td>
</tr>
<tr>
<td>Members who have a stake in a practice but can do a mix of work (Includes: practice owner; employer of any practice staff; registered provider or manager in the practice’s registration with the Care Quality Commission (or equivalent position in respect of HIW in Wales, HIS in Scotland or RQIA in Northern Ireland); Responsible person in relation to any aspect of compliance with a legal requirement (e.g. Information Commissioner’s Office.).</td>
<td></td>
</tr>
</tbody>
</table>

Why does the membership tier matter?

If you’re an associate or practice owner you’ll need to have either Extra or Expert membership (respectively) with us to be eligible to apply for this cover.

Our pricing takes into account the resources that come with your membership.

The range of services available to dentists with Extra or Expert membership is second-to-none and highly regarded. Our one-to-one advisory and support services guide members through tricky times, and the template policies available to Expert members make compliance with national standards straightforward.

Access to this support before things go wrong decreases the risk profile, and because of this, we’ve been able to price the indemnity cover fairly.

We’re here to help

Have the relevant package?
Get an indicative quote and apply.

bda.org/indemnity

Need to upgrade your membership?
Get an indicative quote. If you like what you see call 020 7563 4550 to upgrade your membership then apply for cover.

Not yet a BDA member?

Get an indicative quote. Please join us before applying and purchasing your indemnity cover.

Visit bda.org/join

Are there any exceptions?

Dental care professionals are not registered dentists, so they are not eligible to access this policy. However, in cases where the owner of a practice has cover, any registered dental nurses in their employment will be covered as standard for compensation claims.

Oral and maxillofacial (OMF) surgeons who carry out procedures within the scope of the specialty of oral and maxillofacial surgery within the hospital setting, and who are registered with the GMC, are not eligible to access the policy in this capacity.

OMF surgeons who are registered with the GDC and who carry out oral surgery procedures outwith the hospital setting are eligible to access the policy in this capacity.

The policy is not available to members working in the Isle of Man or Channel Islands.

If you’re a BDA member and a registered dentist working in the UK, then you’re eligible to apply for our indemnity cover.

Get an indicative quote at bda.org/indemnity
# Personalised pricing

To find out how much your cover could cost, get a quote at [bda.org/indemnity](http://bda.org/indemnity)

Quotes are

- Specific to the UK nation(s) where you practise
- Personalised according to the hours you work
- Dependent on whether you provide implant treatment
- Discounted for newly qualified dentists, up to five years post-qualification

## Indicative prices

We know every dentist’s circumstances are different, so no two forms of cover will be the same. To give you an idea of the costs relevant to you, we’ve created some example scenarios.

### Salaried dentist

<table>
<thead>
<tr>
<th>Scotland</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>One day p/w</td>
<td>Five days p/w</td>
</tr>
<tr>
<td>£29.95 p/m</td>
<td>£94.14 p/m</td>
</tr>
</tbody>
</table>

Exclusively hospital/community/university/defence service employed

### Associate

<table>
<thead>
<tr>
<th>Northern Ireland</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Five days p/w</td>
<td>Three days p/w - Implants</td>
</tr>
<tr>
<td>£354.07 p/m</td>
<td>£296.47 p/m</td>
</tr>
</tbody>
</table>

### Practice owner

<table>
<thead>
<tr>
<th>England</th>
<th>Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Five days p/w - Implants</td>
<td>Two days p/w</td>
</tr>
<tr>
<td>£456.16 p/m</td>
<td>£191.59 p/m</td>
</tr>
</tbody>
</table>

Indicative prices shown include Insurance Premium Tax and/or VAT where applicable.

## Comparing prices

Your choice of cover has both personal and professional consequences, so we don’t believe that decision should be based solely on price.

Plus, as with many types of insurance, no two indemnity products will be the same, so comparing price with other providers may not be on a like-for-like basis.

**We're confident we can offer excellent value, as champions of dentists and the dental profession with no other purpose than to provide benefits to UK dentists.**

## Get an indicative quote at [bda.org/indemnity](http://bda.org/indemnity)

Our indicative quotes are intended to give members a broad indication of the possible cost of indemnity cover. They are based on limited information and are not binding or guaranteed. The final purchase price of cover may differ from the indicative quote.

## Once you have a quote, to complete the application form, you’ll need to have available:

- [x] Membership number
- [x] GDC number
- [x] Contact details
- [x] Preferred policy start date
- [x] Details of your previous indemnity history, providers dates and policy numbers
- [x] Details of your registration history
- [x] Details of complaints, claims and investigations
Our managing director Peter Ward explains how BDA Indemnity came about.

“We created this indemnity offering to add another piece to the jigsaw. It’s designed to make sure you’re properly equipped to thrive in today’s professional environment.

Here for your future

There’s lots of talk at the GDC of ‘upstream’ and ‘downstream’ issues and impacts. Our policy work and lobbying is the ultimate upstream support we can give you. We routinely monitor the issues that could have a bearing on your working life, and that of your peers. We gather information, apply expert policy analysis, and then invite you and all members to participate in your own futures. We are run by dentists, for dentists, involving you not just for the future of the BDA but more importantly, the future direction of the dental profession.

Downstream, we calculate the impact of contractual and legislative decisions, and translate this into advice and practical solutions that will actually help you. We recognise the challenges of working within cash-constrained and highly-regulated environments, and we offer you advice about how to avoid the mire of regulation.

Additional support

We actively review clinical and technological advances, and provide education and training on a wide range of clinical and business activities to help our members maintain their professional standards.

Our library contains both state-of-the-art updates on current research as well as historic texts. By deploying modern technologies, we can provide students and researchers with more information than anyone else in Europe. E-books and e-journals enhance our physical collections, and bespoke research packages will help busy researchers. We will even conduct literature searches on your behalf to source the most relevant information available on a given topic.

Our world-renowned dental publications within the British Dental Journal family, represent a unique asset available to you. Add to this our team of expert advisors, ready to support you on all subjects relating to your working life, and you can see the picture is nearly complete.

Prevention rather than cure

You could regard all of the above as the informative and preventive aspect of what we do. By providing such a rich environment of readily accessible knowledge, we can help you keep up-to-date and avoid compliance breaches. The same resources can also help you avoid scrapes and skirmishes with regulators and lawyers.

The integration of the new indemnity offering, together with our vast knowledge base, provides a powerful solution to keep members safe, and to help them if things go wrong.

None of us are immune to mistakes and slip-ups. Compliance with regulations can feel confusing and challenging. Patients have expectations that we may not always identify or meet.

When bad things happen, the world can feel like a lonely place, and this is the time when you really need friends and well-informed support. Our experience tells us that, in those circumstances, dentists are more reassured when they are supported by other dentists with the knowledge, skills and expertise to both empathise and offer genuine help.

New support that’s a natural fit

Building on our long heritage and our broad platform of advice and educational materials, we have now put in place such a structure. We have a team of highly experienced dento-legal advisors to provide the support. We are backed by a recognised major insurer who will provide lasting peace of mind, that if trouble arises, the costs of defence and settlement can be covered.

BDA Indemnity provides contractual, and occurrence-based cover. This means that policyholders can be reassured, with contractual certainty, that their clinical acts and omissions of today are indemnified forever.

We exist only for our members – and we believe this product and its purpose is clear:

It’s dentists for dentists – because together, we are stronger!”

Peter Ward
Managing Director
BDA
A proud partnership

We were clear from the start that if members were to truly benefit from the emergence of another indemnity provider, anyone working with us had to share our values.

The key values we sought from Royal and Sun Alliance Insurance plc (RSA) are the BDA values, that:

- Members are at the heart of everything we do, and
- Together, we are stronger.

RSA has understood our need for cover that works for you in your hour of need - it’s occurrence-based perpetual indemnity for treatments provided during your period of cover. It doesn’t matter when the claim is made; if the incident took place during your policy period, you will be covered.

RSA and the BDA working together

RSA’s Chief Underwriting Officer, Colin Bradbury, explains how we’ll work together, on your behalf:

“At RSA, we’re pleased to be working with Lloyd & Whyte Insurance Brokers and the British Dental Association to provide a new tailor-made insurance product for the dental profession.

The insurance policy provides cover for dentists who inadvertently injure patients while under their care. It covers injury that occurs as a result of treatment provided during the policy period, even if it comes to light some time later. Whether that’s as a result of unintended treatment outcomes, misdiagnosis or a failure to diagnose the cause, or worsening of a dental problem.

The policy also provides protection in respect of legal expenses where injury is involved or, where there is a disciplinary process involving the GDC, which requires legal representation to protect the dentist involved. This clear and transparent insurance policy has been created in collaboration with the BDA to provide an attractive protection proposition for dentists, based on a straightforward pricing structure.

Any queries or patient complaints will be handled by the BDA team, based on their expertise and understanding of the profession. This should enable any issues to be fully understood and solutions developed as quickly as possible.

If necessary, RSA will become involved at a later stage where our wider insurance and claims knowledge of personal injury litigation can assist the process. All of this will involve the close working and collaboration of the member dentist and the BDA to ensure a speedy and effective resolution.

RSA is a UK-based insurance group that’s been dealing with commercial insurance throughout its 300-year history.

We provide a range of liability-based cover for a wide range of industries and professions, including many types of medical occupations, enabling us to build up a high level of expertise in underwriting and handling claims in these areas.”

Colin Bradbury
Chief Underwriting Officer
Commercial Risk Solutions
RSA UK

Get an indicative quote at: bda.org/indemnity
A policy that works for the profession

Since 1880, we’ve been working to make sure UK dentists are supported and protected. And now we’ve created yet another way to do that, with BDA Indemnity.

With us, you get more
You need to have indemnity cover in order to practise. We believe that choosing us as your provider will not only give you long-term, robust cover, but you’ll have access to resources that would make any claim easier to handle.

You’re covered for the day-to-day
If a complaint is made against you, it is very likely that the treatment or interaction that caused the complaint, happened during a normal working day that was otherwise unremarkable.

It’s modern dentistry - the treatments that once were exceptional but are now day-to-day - that we’ve focused on covering. Your choice of indemnity cover really matters.

Read on to see how BDA Indemnity helps you with:

- Communication 11
- Antimicrobial prescribing 12
- Elective cosmetic dentistry and facial aesthetics 14
- Endodontics 16
- Data in your records 18
- Implants 19
- Referral to the GDC 21
- Learning from mistakes 22
- Periodontal disease 24
- Salaried services 26
- Trauma 29
Communication

Communication is either the sole cause, or a contributory factor, in almost 75% of dento-legal cases.\(^1\)

Developing effective communication skills takes time. The process starts in dental school and continues throughout an entire career, as your language skills and methods of communication evolve.

Patients are usually nervous, so anything you can do in that initial meeting to overcome anxiety will make life easier for everyone. In particular, for the dentist and members of the dental team who may be involved in subsequent treatment.

Making a conscious effort to recognize and eliminate your patient’s stress creates its own reward. You’re likely to feel less tired, and the risk of accidents or poor decision-making will also be reduced.

Focus your attention

The first appointment requires you to listen to the patient, distraction-free. Even if you maintain eye contact and nod along as the patient speaks, a ringing telephone in the background can destroy any rapport.

Learn about your patient

To create a successful relationship, you need to understand the reason for the patient’s visit. This requires active listening skills and is something we are not necessarily naturally good at, especially when we have limited time during appointments.

The reason for attending should be noted in their record, along with any personal details that could impact future treatment. You might note down, ‘doesn’t like to be kept waiting’, ‘prefers to be upright’, ‘hearing impaired’ etc. You may discover some aspects of the patient’s social history that might affect their ability to attend appointments. Perhaps, ‘accompanied by a carer’, ‘transport arrangements’, or ‘work commitments’. There is an old adage in healthcare “never treat a stranger” – in other words find out as much as you can about them before you treat them.

Starting the conversation

An open question is a good way to begin.

‘So, what brings you to see me today?’

If you sense the patient is nervous, add a supplementary ‘Is there anything about dental treatment which worries you?’ This may highlight an aspect of treatment that can be adjusted. For example, some children do not like bright lights or flavoured mouthwash.

Attention to detail

Patients measure the standard and value of our services by those extra details that are easily omitted. You (or your practice) could consider calling a patient to check all is well, after they’ve had a treatment that’s likely to cause post-operative pain.

You could also review notes from the previous appointment, before asking the patient how the teeth have settled down. This allows you to refer to the area of the mouth you treated, thereby reassuring the patient you remember them and recognize them as an individual.

---

\(^1\) Practical Risk Management for physicians, Bunting RF et al., Journal of Health Risk Management. 1998 Fall 18 (4) 29-53.
Antimicrobial prescribing

In the last few years, dentists were responsible for prescribing about 10% of all antibiotics in the UK, though that number has begun to fall and now stands at about 5%. A clinical self-audit provides a very helpful tool in promoting this trend.

Deciding whether to prescribe antibiotics might sometimes feel like a balancing act, despite the excellent guidance from FGDP (UK) on prescribing in primary care.

If a patient becomes ill with an infection after treatment and you didn't give antibiotics, there is the small possibility of serious consequences for the patient. This could also lead to a complaint, and all the repercussions that come with it.

However, if you do decide to give an antibiotic as a precaution, it could be viewed as inappropriate prescribing, contributing to antimicrobial resistance (AMR). The dire warnings of an ‘antibiotic apocalypse’ are probably familiar to you. Bacterial resistance to antibiotics would lead to common infections becoming deadly, and medical treatments we currently regard as routine would become impossible.

Prophylaxis

When planning invasive treatment for patients with increased risk of infective endocarditis (IE), you may consider prophylaxis – prescribing antibiotics as a preventative measure. This is a complex decision, which should be discussed with the patient.

The National Institute for Health and Care Excellence (NICE) published guidance in 2008, stipulating that antibiotic prophylaxis shouldn’t be used in this scenario. This was a clear instruction, based on a lack of reliable evidence in favour of the effectiveness of prophylaxis. Plus, there’s the very real problem of AMR, as well as the risk of a patient’s adverse reaction to the antibiotic.

Despite this, many patients and dentists had grown accustomed to prophylactic antibiotics, and some cardiologists objected to the new position.

Guidelines

NICE eventually updated its guidance, after we debated the issue along with academicians and clinicians. The update stated that prophylaxis should not be ‘routinely’ provided for patients at increased risk of IE.

To clarify this further, the Scottish Dental Clinical Effectiveness Programme (SDCEP) gave dentists advice on how to implement the revised guidance, and produced information leaflets for patients. The BDA contributed again with suggested changes, to make sure the documents were clear and helpful.

The resources provided by SDCEP offer advice on which patients might be at increased risk of IE, and should therefore be considered for non-routine management. They also highlight the key decision-making role that patients have when it comes to their own care. The guidance offers support for dentists to engage with patients and their cardiologists, so they can identify special cases where antibiotic prophylaxis should be considered.

Antimicrobial stewardship

More broadly, we’ve been working since 2014 to integrate dentistry into the UK AMR agenda. We brought together dental, medical and veterinary experts for the ‘One Health’ expert summit. At the time, dentists were prescribing about 10% of all antibiotics in the UK – a fact that was largely overlooked by the developers of national antimicrobial stewardship strategies.

The summit identified some key drivers of over prescribing antibiotics in dentistry. These included pressure from patients, fear of the consequences if a patient became ill, and perverse incentives found in the dental contract.

On your behalf, we have been lobbying for funded NHS urgent treatment timeslots, which would give you more time to perform a clinical intervention on patients in pain, rather than inappropriately prescribing antimicrobials.
In conjunction with Public Health England and the Faculty of General Dental Practice (UK), we’ve also developed a dental antimicrobial stewardship toolkit, including a prescribing self-audit tool. You’re encouraged to use it to make sure that the medication you’re prescribing complies with the FGDP’s guidance.

bda.org/amr

The future of antimicrobial prescribing

The good news is that antibiotic prescribing in dentistry has begun to decline, but there is no room for complacency. We’ll keep supporting you and your patients to make the best choices.

We know you want to be socially responsible. This means providing the best care for your patients, and making efforts to keep antibiotics working well for as long as possible. We’ll continue to work on your behalf on this crucial issue, to find the right balance.

Where antimicrobial prescribing is concerned, it can sometimes seem like a dentist is open to criticism and challenge whatever you do. The BDA is actively involved at the centre of this debate so we are ideally placed to help and support you.
Elective cosmetic dentistry and facial aesthetics

You are managing the individual aspirations and expectations of a patient alongside all the technical and clinical challenges. Neither are straightforward, and both introduce risks which need to be understood and carefully managed.

Cosmetic dentistry

Elective smiles

Many patients now visit a dentist not because they’re in pain, or exhibiting signs and symptoms of oral disease, but because they want to improve the appearance of their teeth, or enhance their smile.

Elective dental treatment has been fuelled in part by the media, TV ‘make-over’ programmes and social media influencers.

Alongside this growth, there has been a commensurate increase in complaints and litigation associated with these procedures, particularly with:

- Veneers
- So-called ‘smile makeovers’ and full mouth rehabilitations involving multiple fixed restorations, often including some veneers
- Elective orthodontic procedures including ‘six month smiles’ and other such techniques and the use of clear aligners.

Although the nature of these treatments differ widely, as does the technical complexity, five main reasons that problems tend to arise:

1) Expectations

Particularly, a failure to recognise, understand and proactively manage the patient’s expectations, from start to finish. This could also include promising more than you can realistically deliver, perhaps coupled with marketing material that implies you have special skills and training in this field.

2) Case assessment

Failing to recognise the specific complexities of each clinical situation, which hampers the ability to manage potential complications. This applies particularly when dentists are over-ambitious and overconfident regarding their knowledge and training, experience and competence in the type(s) of procedure and techniques involved.

3) Shortfalls in the consent process

Relying upon ‘one size fits all’ website content, or other generic patient information, then failing to tailor the details and warnings (like potential risks and limitations) to the individual patient and their specific circumstances.

4) Satisfaction and value

These treatments are usually carried out on a private basis and may carry a significant price-tag. The patient’s perception of the outcome will be based not just on their first impressions, but how they feel over the course of the following months and years.

5) Compliance and the unexpected

Where orthodontic aligners are concerned, this introduces additional complications especially with patient compliance and retention. Issues may also arise if teeth lose their vitality, or if restorations fail prematurely, without the patient having been adequately prepared for such outcomes.

Changes in law

Dentists and practices should be mindful of important changes in the law, such as the UK Supreme Court’s decision in the case of Montgomery v Lanarkshire Health Board (regarding the requirements for a valid consent), and the Consumer Rights Act. When coupled with earlier consumer legislation, you’re under the same obligations and risks as any other business, regarding (1) and (2) above.

The GDC has made it clear that its own requirements are no less demanding than the law (and in some cases, additional requirements must be satisfied). One time-honoured ethical principle of particular importance is making sure you’re putting the patient’s interests above your own (and above any commercial interests) at all times, and doing nothing that will leave the patient worse off than when they first visited.
Aesthetic facial procedures

Registered dentists are well qualified to provide non-surgical cosmetic facial procedures such as the use of botulinum toxin and injectable dermal fillers.

In its *Scope of Practice* guidance document, the GDC specifically identifies ‘non-surgical cosmetic injectables’ as an example of the additional procedures that a registered dentist can undertake once they have undertaken additional training, and are sure they have the necessary skills and are appropriately trained, competent and indemnified. The GDC’s approach to implant dentistry is exactly the same. BDA Indemnity follows a similar approach.

The policy has been designed to cover the full range of cosmetic facial procedures, but within fair and reasonable boundaries in the interests of all policy holders. Reflecting this principle:

- Cosmetic injectable procedures (such as Botulinum Toxin or Dermal Fillers) are automatically covered in the peri-oral area, throughout the face, glabella, forehead and ‘crows feet’ around the eyes – but these procedures are not covered when used in the neck or below the lower border of the mandible.
- Other kinds of cosmetic facial aesthetic procedures involving the use of lasers, intense pulsed light (IPL) energy devices, electrotherapy or dermabrasion are not covered at all, and similarly the use of these or other techniques to remove tattoos or pathological blemishes anywhere in the body, are also excluded.

Communication

Ultimately, the success of any cosmetic procedure depends on the extent to which patient expectations have been met. Understanding the patient’s motivation, wants and needs, hopes, fears and concerns is essential before providing any cosmetic treatment.

An obvious preliminary question is, ‘what kind of change or improvement in appearance is the patient looking for, and why?’

Then ask – ‘why now?’ Is there an underlying motivation related to a third party or an issue concerned with the patient’s work life, social life or personal life? Establish the patient’s motivation at the start so you know what you are really dealing with. Patients in the spectrum of body dysmorphia and obsessive-compulsive disorder can be challenging in this respect and may benefit from initial counselling by a clinician familiar with these conditions, before undertaking any treatment.
Endodontics

Endodontic procedures offer important clinical outcomes. They also come with their own range of potential misadventures. It’s critical to protect the patient’s airway during endodontic treatment, to avoid a clinical negligence claim. If something does happen that could impact on their treatment, be sure to tell them as soon as possible.

A case study

A patient returned to the practice after a two-year interval. Before that, they’d been a regular attender. They complained of pain on biting, and a swelling of the lower left side of their mouth. A periapical radiograph was taken (Figure 1) revealing two radiolucent areas on LL6. The patient was informed.

After discussing the options, the patient agreed to try and save the tooth and make an appointment for endodontic treatment.

There are some critical features to note in this radiograph (fig.2). The first and most obvious is the lack of a rubber dam and rubber dam clamp, to protect the patient’s airway from inhaled endodontic instruments. If a patient swallowed or inhaled an endodontic instrument in this scenario, this dentist would have been liable for any clinical negligence claim.

The second important feature is the curvature of the mesial canal. This adds to the complexity of the case and the patient should have been advised of this, as part of valid consent.

Unless the general dental practitioner (GDP) felt they had sufficient skill and the right equipment to deal with the curvature of the mesial root, the patient should have been given the option to be referred to a specialist.

There are guides to assist dentists in establishing the complexity of a particular endodontic procedure\(^1\), so they can have a practical discussion with the patient, and come to a shared decision.

In this event, the dentist provided root canal treatment and unfortunately separated an instrument in the mesio-buccal canal of the LL6. He was rather embarrassed and decided to tell the patient on another day, when they returned for a check-up. As it happened, the patient cancelled their next appointment, having moved away from the area.

The patient had no problems from the tooth in the intervening three years, but attended a new dentist when a small piece of filling broke off the LL6. A radiograph taken at the time (Figure 3) revealed the broken instrument. Interestingly it also showed that the mesial periapical area had healed and reduced in size around the distal root.

---

3. Restorative Dentistry Index of Treatment Need Complexity Assessment Department of Health and Clinical effectiveness Committee Royal College of Surgeons
The patient was shocked to learn about the broken instrument in the canal, which their previous dentist hadn’t mentioned. The patient’s lawyer contacted the practice claiming the dentist had failed to offer a referral before undertaking complex endodontic treatment, and had failed to inform them about the separated instrument.

To avoid similar problems in the future you have to ask why the treatment had failed (see ‘Learning from mistakes’ page 22). This process would reveal issues around communication, consent and clinical endodontic skills.

You’ll have the peace of mind of knowing that you’re protected forever against any claims relating to failed endodontic treatment undertaken during the policy period – no matter how many years have passed since you treated the patient.
The data in your records

A dental practice generates and collects new data all the time. This means the practice owner needs to have systems in place to make sure all the data is properly stored, can be reliably retrieved and, when necessary, disposed of securely.

The retention of records in the UK is governed by the Data Protection Act 2018 (DPA) that incorporated the EU General Data Protection Regulation (GDPR) into domestic law, and thereby established what information must be kept, and how it should be handled. Whilst not intended as a complete list of the documents created by a dental practice, the examples below serve as a reminder that in addition to patient records, many of your business records fall within the scope of data protection legislation.

Retaining information

It’s a legal requirement that any information gathered by your business is retained for a legitimate purpose, and for no longer than necessary.

Whilst the DPA and GDPR do not specify retention periods for all records, it is likely that most records will contain some information that’s subject to a statutory retention period. If that’s not the case, there will usually be a recommended retention period.

HR records

HR records will typically capture information concerning salaries, pensions, absences, disciplinary matters and relevant health information. Some of this information is subject to a statutory retention period. Accident books and records should be stored for three years from the date of the last entry (or, if the accident involves a child/young adult, then until they reach 21). Income tax and NI returns, tax records and correspondences with HMRC should be retained for no less than five years after the end of the relevant financial year.

Payroll records should be kept for six years, from the end of the relevant tax year. Statutory maternity pay records and National Minimum Wage payments should be kept for three years after the end of the tax year in which the payment period ends. Meanwhile, working time records should be kept for two years from the date they were made. If HR records contain information for which no statutory retention period has been published, the employer can decide how long to keep it. In terms of recommendations, as most employment tribunal claims must be brought within three months of the incident, relevant information should be retained for three months. Also, since the Limitation Act 1980 creates a six-year time limit for starting contractual claims, relevant information should be kept for six years.

For personnel files and training records (including formal disciplinary records and working time records) – keep them for six years after employment ceases. With recruitment application forms, interview notes (for unsuccessful candidates), and records relating to vacancy advertising and job applications – keep those for a year.

Financial and other business files

Contracts with suppliers need regular review, so documentation should be retained for six years after cessation, in case a contractual claim arises. Accounting records have a statutory retention period of three years for private companies.

Secure storage and archiving

To comply with legislation, practices must have appropriate security. Specifically, practices need to protect personal information against unlawful or unauthorised processing, and accidental disclosure or loss. Personal information should never be left unattended, and personal health information requires a high level of security because of the potential damage that unauthorised disclosure might create.

Paper records should be stored in lockable, fireproof cabinets and the premises should be protected to prevent entry by intruders. Digital records should be protected by passwords known only to essential staff. CCTV recordings must be stored securely and in a way that maintains the integrity of the image. Access to the images should be restricted and the images deleted when no longer needed.

* Not virus or unauthorised access-related. In addition, there must be proper procedures for security and daily back-up of documents in place.
Implants are forming an increasingly important part of mainstream dentistry. More implants are being placed, in more clinical situations, by more dentists.

Considering this rise in popularity, it’s hardly surprising that implant dentistry features more prominently in complaints and litigation\(^1\). Also, the costs of implant claims typically rank higher than average.

On the other hand, the evidence base is continually improving, and clinical outcomes can and should reflect that.

While it’s entirely fair and appropriate for clinicians who place or restore implants to pay a little more than those who don’t, that price difference needs to be reasonable.

Otherwise, well-trained and experienced clinicians would be unfairly penalised. This would be particularly unfair for those who are extensively involved in implant dentistry, without incident or complaint.

Treating patients with implants

Increasingly, many practitioners who don’t place or restore implants themselves, are still encountering patients who have implant fixtures, as well as implant-supported restorations and appliances.

Most practitioners will approach this in the same responsible way they’d approach similar situations: if a clinical situation falls outside their experience, skill-set or competence, they’ll seek guidance or refer to others. In implant dentistry, this can even apply if the dentist is unfamiliar with the specific implant system/fittings involved.

But if a clinician is confident in their ability to treat their patient, (for example provisionally re-attaching a restoration to an implant fixture/abutment), they should be able to do so without complicating or invalidating their indemnity. We’d consider this a part of ‘normal’ clinical dentistry.

What might go wrong?

Both the surgical and restorative/prosthodontic aspects are equally likely to be the cause of complaints and litigation. This is why we make no distinction between the two. Shortfalls in patient assessment and treatment planning are often the underlying problem, which is the case for many other areas of dentistry.

Monitoring the health of a patient’s previous implants and restorations/appliances is just as important as any new work. So it’s becoming more important to recognise any incipient failure in the health of the supporting tissues.

Uncomfortable questions

As stated in ‘Standards for the Dental Team’, the professional guidance document from the GDC, you must only carry out a task or a type of treatment if you’re appropriately trained, competent, confident and indemnified. If you’re not confident with providing treatment, you must refer the patient to an appropriately trained colleague.

So you should ask yourself whether you’d feel confident justifying your decision to perform the treatment, in a court of law, or before the GDC. Could you demonstrate that you’d been trained adequately and appropriately to carry out implant dentistry?

You should also ask yourself if you can safely carry out an acceptable standard of treatment.

Follow up and ‘late failure’

There’s growing evidence that many implants that appear to be initially successful, begin to show signs of failure later on (what is commonly called ‘late failure’). This could be due to ‘peri-implantitis’ or other issues.

While most of these claims can be defended, you should expect close scrutiny here, particularly of whether you:

- Identified and managed any relevant risk factors
- Gave appropriate post-operative advice to patients, if at all
- Monitored the health of the implant/restoration in situ
- Took the right steps, at the right time, if the situation deteriorated.

Similarly, you should feel confident about the information and warnings you give to patients, and how well you manage their expectations. This applies to the consent process, as well as the occasion you placed the implants/restorations.

\(^1\) Managing Implant Risks, Abhi Pal, SoundBite, MDDUS, June 2017

\(^*\) The policy has a £10 million limit on claims arising from any single policy year.
Implants covered by BDA Indemnity

You can choose whether or not you’d like to be indemnified for placing and/or restoring implants. However, if you’ve only been practising dentistry for a few years since qualifying, we strongly encourage you to gain more experience and undertake specific training before getting involved in implant dentistry.

A pragmatic approach
There aren’t any hidden extras, so there’s no additional loading for bone grafting, or sinus lifts. They’re both automatically included with the implant category, which removes any uncertainty if complications arise during surgery. However, bone harvesting from the ribs, iliac crest or any other part of the body, other than the maxilla and mandible, is not covered.

The products you use
Product liability claims are included with BDA Indemnity – unless you deliberately act outside of best practice, like using implant fixtures or bone grafting products that are known to be defective, or unfit for purpose.

So-called ‘mini implants’, used as temporary anchorage devices (TADs) in orthodontic treatment, are covered within normal rates – no need to move into an implant category and pay more.

Flexibility
The additional cost of including cover for implants is not a flat-rate sum across all categories. To keep it fair, costs depend on your level of activity, so if you’re working part-time, or you’re not a practice owner, you won’t be penalised.

If you start placing or restoring implants in the middle of your policy year, you’ll only pay the higher rate from the date you start.

Is ‘late-failure’ covered?
Data shows that half of all claims don’t come to light until three or more years after treatment – problems with implants can occur years later.

How BDA Indemnity can help
BDA Indemnity is occurrence-based, so you have the peace of mind of knowing you’re protected forever. As long as you had the appropriate implant cover at the time of treatment, you’ll be protected against any late failure claims.
Referral to the GDC

If you’re summoned to appear in front of the GDC, you need the best support available. BDA Indemnity eliminates any risk that you’ll have to represent yourself.

Most of us are surprised when we learn that anything we do in our personal and private life is just as likely to be investigated by the GDC, as the things we do in our professional life.

In fact, the GDC has faced much criticism in recent years for their tendency to investigate things most other healthcare regulators would consider immaterial, and beyond their legitimate remit.

The ultimate sanction

This may seem all the more surprising since the GDC has the ultimate sanction at its disposal – taking away a dentist’s dental registration, and with it, the ability to practise dentistry or to own and operate a dental practice.

Even courts of law don’t have that power, and being sued many times doesn’t impact a GDC registration.

An unexpected letter from the GDC is something every dentist dreads. That’s why members need a very particular kind of help, support, and representation if such a letter lands on the doormat.

Help is at hand

There’s no substitute for first-hand experience when it comes to dealing with fitness to practise investigations. This kind of experience will help in several ways:

- Understanding the aspects of a complaint that are likely to be of most concern to the GDC, its case officers, and the committees involved
- Knowing how to construct the best possible response to the GDC
- Giving you the expert help, independent advice and the personal support you’ll need, from an experienced dental colleague
- Sharing relevant personal experience in these matters, and we’ll be able to genuinely empathise with you
- Providing you with specialist legal representation from expert law firms, making sure your interests are protected at all times
- Selecting the right legal team to represent you in the event that a hearing proves necessary
- Putting yourself in the best possible position to avoid a finding of ‘misconduct and current impairment’ being made against you.

The experience of going through a GDC investigation can be extremely stressful. Plus, the extended length of time it can take to conclude a case (see Figures 1 and 2), makes it invaluable to have a team of knowledgeable and supportive people around you, who understand the details of your case, and with whom you can privately discuss any concerns.

Always actively engaged

We’re the trade union representing you, and we have regular meetings with the GDC in order to fully understand the latest developments, behind the scenes.

Plus, we’ve been outspoken on many occasions, regarding the way the GDC regulates our profession. In the process, we’ve gathered a wealth of information that can be used to support you if you find yourself summoned to appear before the GDC.

You’re guaranteed assistance with GDC investigations, disciplinary and/or administration proceedings, whether or not it results from clinical dentistry.

You’ll get the right help when you need it most, including guidance on navigating media or social media issues.

Figure 1

Fitness to practise cases - investigation stages
Time from first receipt at GDC to reach decision
(eg whether or not the case is referred for a hearing)

Source: General Dental Council Annual Report 2017

Figure 2

Fitness to practise - cases requiring hearing(s)
Time between investigation decision and initial hearing

(In 5% of cases the time between an initial investigation decision and completing an initial hearing is >2 yrs)

Source: General Dental Council Annual Report 2017
Learning from mistakes

Sub-optimal outcomes present the opportunity to learn something and improve. We should notice when things don’t go to plan, reflect on why it happened, and we should always identify how we can prevent it from happening again.

Perfection is a moving target. What seems like perfection today, may seem very ordinary with the passage of time. It is not perfection which we should be striving for, but excellence – an equally rocky path, littered with mistakes and unforeseen complications.

Along the way
From the very first time a dentist picks up a handpiece, to the very last time they hang up their dental uniform and retire, there is one absolute certainty – there will have been some mistakes along the way.

There’ll be fewer as you become more experienced, and they’ll probably be less critical to the overall success of the patient’s care. But still, you’ll encounter sub-optimal events. As well as clinical issues, poor communication and patient management, this includes anything that didn’t go according to plan, and which on reflection could have been prevented.

The essence of professionalism involves noticing these events, and stopping occasionally, to review the causes.

Why?
‘Why did that happen?’
‘Why did that not happen?’

Reflection is a skill that is currently taught to all dental undergraduates. It’s also an integral part of the learning experience during the dental foundation training year. The process might not be so easy if you missed that formal input when you were an undergraduate, but there is an equally valuable process every dentist intuitively has: so, when a crown or an implant fails, you ask yourself ‘why?’

Failing to ask yourself that question or discussing it with colleagues robs you, your dental team and the patient of the learning that could prevent it happening again.

‘Why did the patient complain?’; ‘Why did we give the patient penicillin when they were allergic to it?’; ‘Why was the wrong tooth extracted?’

There are any number of questions and plenty of techniques to tease out the reason for a poor outcome.
The “Five Why” technique

This component of root-cause analysis was developed in the car industry. Taiichi Ohno worked for the Toyota Motor Corporation in Japan, where he applied the technique of asking ‘why’ five times to determine the nature of the problem, as well as assisting in providing a solution. The NHS has recently adopted this concept as well.

Example: A patient with a penicillin allergy was prescribed amoxycillin by the dentist and was later hospitalised with a severe allergic reaction.

**Why?** Dentist did not check the medical history on the computer

**Why?** A note about the allergy was on the original medical history questionnaire completed by the patient four years earlier but it was buried in other data on the form

**Why?** No system to alert the clinician about significant health issues

**Why?** This had never happened before and the ‘pop up’ note feature on the computer had never been activated

**Why?** No review had been performed of the practice system for prescribing medicines. Nor had there been an audit of the drugs prescribed, by whom and for what purpose.

This process identified some personal needs and system improvements. and whilst often problems arise due to human error at the patient to dentist interface, there can be latent system errors that may also give rise to a problem.

If you should ever be in front of the GDC, we’ll help with a remediation plan for professional development, to get you back on track and mitigate the risk of sanctions.
Periodontal disease

Claims involving periodontal disease may go back many years, and involve several dentists, which makes record keeping essential. It’s also important that we help patients understand their own role in managing their disease.

Periodontal disease isn’t a new phenomenon in the UK, though the activity of ‘no win – no fee’ law firms certainly is. In recent years, there’s been a reported growth in claims that include allegations of undiagnosed/poorly managed periodontal disease.

With rare exceptions, dentists do not cause periodontal disease. But given the fact that 50% of the adult population has some kind of periodontal disease¹, the ‘no win – no fee’ law firms have plenty to work with.

These allegations could be particularly attractive to such firms because of their high cash value, making them commercially profitable to pursue. This is especially true if the claimant can provide a way to get around the ‘limitation period’.

Time limits

In clinical negligence cases, the law says a claim needs to be made within three years – this is the ‘limitation period’. After that time, a claim becomes ‘time barred’ (struck out). Normally, the three years starts from the date of treatment.

However, in cases where there’s a failure to diagnose or delayed diagnosis/treatment, the patient may argue that the three years should start from their ‘date of knowledge’, which is the date they actually discovered the problem.

In these situations, the claimant can apply for the court to set aside the limitation period. Some indemnity providers take the short-sighted view that periodontal claims can’t be defended – that it’s not worth challenging ‘out of time’ claims, since they incur additional legal costs. In actual fact, this approach simply invites more ‘out of time’ claims.

The courts have reaffirmed that limitation periods are there for a good reason, so they should be respected. This puts the onus on the claimant to persuade the court that their claim won’t be prejudicial to the defendant, if it falls outside the limitation period.

Sometimes, periodontal claims are made for treatment that was received so many years ago, the defendant may no longer have any relevant clinical records for their defence. This is a classic example of how a dentist might be unfairly disadvantaged if a late claim went ahead.

¹British Society of Periodontology http://www.bsperio.org.uk/patients/
How BDA Indemnity can help

Periodontal disease claims can easily stretch through time. Even if it’s years until you receive a complaint from a patient you’re treating now, you’ll be fully covered.

Causation

Every clinical negligence finding needs to show that a particular act or omission from a clinician was the probable cause of the patient’s harm. In other words, the claimant needs to prove the dentist caused them harm, on the balance of probabilities.

For example, an allegation was made against a dentist, claiming the dentist hadn’t provided effective advice to help the patient stop smoking.

Since the patient had periodontal disease, the claim was that the dentist caused their disease to worsen. Instead of simply accepting this as fact, it’s important to question whether the patient would have acted any differently if they’d received different advice.

If the evidence suggests that the patient would’ve probably continued smoking, then it’s clear that the dentist’s advice didn’t have a causal relationship with the progress of the patient’s disease.

Equally relevant would be any other concurrent factors that could or would have made the progression of the periodontal disease highly likely in any event.

Identify, manage and monitor it

The central issue is that periodontal disease is the patient’s responsibility to manage, and the risk factors are usually beyond our control. Our role, as the clinical team, is to screen every patient to identify it. We can then quantify its nature, severity, extent and rate of progression, and inform the patient, being sure to record all of these steps. The patient needs to understand their condition, what they can do to manage it, and how we can help.

We also need to explain the consequences of not acting on our advice and treatment recommendations. Again, these conversations should be recorded and dated. After that, we need to regularly review the patient’s progress and whether or not they’re following the advice they’ve been given. Where necessary, we can then provide follow-up treatment or offer a referral, such as to a periodontal specialist. After all, the long-term management of this disease falls to the patient, so they’ll need to actively participate in this process.
Salaried services

(For members employed within hospitals, community dental services, universities and the defence service)

As your trade union, we’re in a unique position to provide you with all-round support and a bespoke service. We understand the dental profession and your potential needs. Your employer provides you with clinical negligence cover, and BDA Indemnity extends that protection so you’re fully covered.

Vicarious liability

If you’re salaried, it’s your employer who’s responsible for any negligent acts and omissions you may carry out, whilst performing any work laid out in the terms of your employment contract. Most employers have indemnity/insurance arrangements to protect themselves against these claims.

Because the employing organisation/entity is the primary party in this type of situation, as the employee, you’re indemnified as a by-product of your employer’s indemnity arrangements. The outcome for you would be secondary to that of your employer, unless you have your own indemnity for such situations.

NHS employees

Most (but not all) hospital and community services are partially protected by NHS indemnity, and any negligence claims made against them are managed by NHS Resolution (formerly the NHS Litigation Authority – NHSLA). The financial cost is covered on their behalf.

WHAT NHS INDEMNITY COVERS (AND DOESN’T)

What’s in

Negligence claims relating to work done under the specific terms of your employment by the NHS entity – reflecting the place of work and hours specified in that contract

What’s out:

Any access to (or the cost of) advice, support or representation in relation to GDC investigations and hearings

Internal disciplinary investigations or performance challenges

Reports or evidence given in the capacity of an expert witness, for which you are paid by third parties unless specifically required by the terms of your employment by the NHS, and done on the instructions of your employer

Any other Category 2 work as defined by the terms of NHS employment

Employment issues, such as disputes with your employer

Allegations of plagiarism, research impropriety, or violations of intellectual property like the use of images in lectures or articles

Any allegations involving defamation, libel or slander

Any access to independent personal advice and support for complaints/claims made against you, even though the financial cost of the claim itself is being met by your employer

Matters challenging your reputation or integrity (such as from the media/social media), or situations where your employer wishes to make public statements designed to protect its own position, and there is a conflict with your own best interests

Similar arrangements apply if you’re employed by universities, or the Ministry of Defence, although the details may vary slightly

Industrial and commercial employers

Dentists who are employed by commercial companies working in and around dentistry, may or may not be required by the terms of their employment contract to hold their own professional indemnity. Self-employed consultants, advisers and contractors will usually be required to do so.

This wouldn’t affect your employer’s vicarious liability even (in some circumstances) if you are considered as self-employed. But it may affect your employer’s decision to recover some or all of the costs from that indemnity provider.

Membership benefits

Our employment relations team provide direct support if you’re in salaried employment, anywhere in the UK (excluding Isle of Man and Channel Islands). If you’re working in the salaried primary dental care services (or the public dental service for Scotland, or community dental service for Northern Ireland), are a clinical academic
working in dental schools, you’re a consultant in dental public health, working for Her Majesty’s Armed Forces, or if you’re employed directly by a social enterprise or for profit company, you can contact the employment relations team for assistance on work related matters.

**Call 020 7563 4585 or email employmentrelations@bda.org**

**Workplace negotiations**

Through our role as a trade union, we are recognised by NHS trusts and health authorities/boards as the body representing dentists. As such, we can be consulted over changes to services and working arrangements. If workplace consultation doesn’t take place, we can seek remedies through both informal and formal channels. We regularly assist members with non-clinical disciplinary matters, incorrect pay or grievances about a situation at work.

If you work within the hospital dental service you can contact us. This is part of a contractual agreement we’ve made as your union with the British Medical Association (BMA), to provide advice and representation for our members working in hospitals. Call 0300 123 1233.

A few larger organisations promote or endorse a particular indemnity product and give employees no choice of indemnity provider. This may create a number of different conflicts between the interests of the individual dentist, whether an employee or self-employed, and the interests of the entity. You may, for example, be subject to a disciplinary process by the entity. Additionally, the individual dentist may not be allowed to respond to claims, complaints and other challenges in a way which exposes the entity to criticism, liability or reputational (brand) damage and the dentist may be left carrying the can. It is crucial that dentists should be free to protect their individual position, reputation and integrity and to have access to independent, personal advice with this in mind.
Close the gaps
Many dentists working in various branches of the salaried services are oblivious to the variety of ways that gaps can exist in their professional protection.

The solution
- All your advisory, support and indemnity needs covered
- No duplicated costs - you pay for what you get and get what you pay for
- No gaps left because of an incomplete fit between products from different providers and/or a failure to appreciate and understand what is covered and what is not
- Your personal interests protected at all times

BDA Indemnity cover for those exclusively employed in hospital/community/university/defence services:

BDA Indemnity
Covering the situations that NHS indemnity is not designed to cover

Essential membership
Including workplace representation

NHS INDEMNITY
Or equivalent indemnity through your employer

Professional Liability Insurance from RSA
Legal representation ✔
Crisis management ✔
HMRC tax investigation expenses ✔
Whistleblowing ✔

Advisory, case management and indemnity support from the BDA
Case management and dento-legal advice ✔
Support with professional disputes ✔
NHS contract and performance disputes ✔
Intellectual property disputes ✔
Academic and research disputes ✔
Advertising and competition advice ✔
Reputation management ✔
Remediation ✔
Associates/employees ✔
Quotes are personalised for hours worked and are UK nation-specific ✔

The cover is designed to ’wrap around’ the employer-provided indemnity, giving the member extra peace of mind.
Trauma

In clinical situations it’s better to be proactive, rather than reactive. Though challenging, effectively responding to a dental emergency creates a perfect opportunity for building your reputation.

Most dentists have been confronted with a tearful child, who’s broken a tooth while playing. The child and the parent arrive in the middle of a busy day, without warning, and they’re looking to you for reassurance, and a speedy solution to the problem.

Shocked patients
Young children who injure their front teeth are usually shocked, and so are their parents. They’ll be looking for a professional response when they seek help from your team, as well as a good aesthetic result. Fortunately, new materials and techniques have increased the treatment options for these types of dental emergencies.

These types of traumatic injuries aren’t limited to playing children. Contact sports, cricket balls, hockey sticks, skate boards, bicycles, skis of various kinds, horses and ponies, and the shallow end of swimming pools – all of these feature prominently amongst the causes of traumatic dental injuries.

Responding to emergencies
Usually, your team will be asked to treat the patient without any warning. Unless you regularly treat patients who have damaged their teeth in an accident, you may not necessarily feel confident about how to manage the situation. You may feel inclined to refer the patient elsewhere, even if the resultant delay could cause dento-legal problems.

Plus, if your patient senses any hesitation or reluctance, they could misinterpret it as a lack of care or concern. Meanwhile, if you or someone on your team refuses to see the patient, or don’t offer any ‘out of hours’ options, this could generate a complaint.

Problems can also arise from the treatment itself. It could be that the short notice to provide an unfamiliar treatment leads to a suboptimal result. Fortunately, there’s a guide to remind you what to do in these situations, based on the latest best practice (things could have changed since you last reviewed the topic).

How BDA Indemnity can help
Claims involving minors do not need to be brought until the child is aged 21. Occurrence-based BDA Indemnity gives you the long-term confidence that you will still have a legally binding right to be covered, perhaps 10 or 15 years after treating a child with dental trauma.

Take control of trauma
Check out the websites dentaltraumaguide.org and dentaltrauma.co.uk and save them as favourites on your practice computer, for these types of unexpected moments. The more you and your team familiarise yourselves with these situations, the better. This will ultimately improve your response to these events, which will inevitably arise at the practice when you least expect it.

The websites help you classify the injuries you might see, giving you a blueprint for how to treat patients with similar injuries. With a few clicks you can find the relevant protocol, and be assured that you’re following current recommendations.

Even if you don’t use these resources before treating a patient, they can still be useful afterwards. If you can demonstrate that you and your dental team have taken time to refresh your knowledge of the subject, you can reduce the risk of potential claims being successful. In turn, your patient is likely to go away feeling reassured, sharing their positive experience with their network. This could work towards raising the profile of your practice.

Your reputation
It shouldn’t be overlooked how much of a positive impact it can make on the perception of your practice, when you make a real effort to accommodate emergency patients. They’ll often become vocal and enthusiastic ambassadors for you. Predictably enough, the reverse is also true, and a failure to provide emergency care can create a reputation for being uncaring. A complaint fuelled by a patient’s anger at being left to suffer isn’t easily resolved.
Round up

A unique service designed for dentists and dentistry exclusive to BDA members

With us, you’ll get:

**Peace of mind**
A contractual right to cover under the policy means you’ll have peace of mind that when an incident occurs under the policy, you’re covered forever. We state what is covered and what isn’t so there’s no uncertainty.

**Future-proofed indemnity**
The recent Government consultation on professional indemnity has expressed concerns about discretionary indemnity and the lack of regulation of discretionary providers, and similarly the potential gaps left by many claims-made policies. BDA Indemnity is already regulated, it offers contractual certainty rather than discretion, and is occurrence based rather than claims-made. It is already fit for the future.

**Dentist-to-dentist support**
You deserve support from experienced dentists with legal knowledge, in times of pressure. Ask us anything – we’re here to help.

**Flexible cover**
Your cover needs to be just as flexible as the way you work, where you work, and what you do.

**Key facts: bda.org/indemnity**

Indicative prices

Example prices for members are provided as a guide only. Complete the short online form for an indicative quote for cover. A precise quote for your consideration will be given upon application and acceptance.

<table>
<thead>
<tr>
<th></th>
<th>Up to 400 hours per year</th>
<th>Up to 1200 hours per year</th>
<th>More than 1600 hours per year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Associate</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No implant work</td>
<td>£76.86</td>
<td>£230.56</td>
<td>£354.07</td>
</tr>
<tr>
<td>Implant work</td>
<td>£95.80</td>
<td>£296.47</td>
<td>£394.40</td>
</tr>
<tr>
<td><strong>Practice owner</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No implant work</td>
<td>£113.07</td>
<td>£296.47</td>
<td>£394.40</td>
</tr>
<tr>
<td>Implant work</td>
<td>£132.55</td>
<td>£342.64</td>
<td>£456.16</td>
</tr>
<tr>
<td><strong>Employed</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>£25.33</td>
<td>£59.59</td>
<td>£94.14</td>
</tr>
</tbody>
</table>

Our indicative quotes are intended to give members a broad indication of the possible cost of indemnity cover. They are based on limited information and are not binding or guaranteed. The final purchase price of indemnity cover may differ from the indicative quote.

Indicative prices shown include Insurance Premium Tax and/or VAT where applicable.
What’s covered:

- Comprehensive indemnity for damages and legal costs - £10 million limit on claims arising from any single policy year
- Vicarious liability for the supervision, training and mentoring of others and for the actions of people working in your practice
- Defence costs including those related to GDC matters
- HMRC cover
- Defamation cover
- Botox, whitening and fillers cover
- Cover for implants if you do them
- Compensation for colleagues attending claims hearings on your behalf
- Report writing
- Publication of articles
- Good Samaritan acts
- Providing volunteer dental services abroad for charitable organisations
- Reputation management
- Cover for nurses.

For full policy benefits and limitations, please go to bda.org/indemnity/policy

How to apply

bda.org/indemnity

1. Complete the short quote form online. The indicative quote is sent to your inbox.
2. Like what you see?
3. Complete the online application form. We’ll review and provide a final price.
4. We’ll call you to set up the Direct Debit*.
5. You’re protected!

* You may need to upgrade your membership at this point.

About the BDA

We bring dentists together, support you through advice and education, and represent your interests. We now provide a comprehensive indemnity policy designed specifically for members.

As a trade union and professional body, we represent all fields of dentistry including general practice, community dental services, the armed forces, hospitals, academia, public health and research.

We are owned and run by our members and all our income is reinvested for the benefit of the profession.

To apply, you will need to have the following ready:

- Membership number
- GDC number
- Contact details
- Preferred policy start date
- Details of your previous indemnity history, providers’ dates and policy numbers
- Details of your registration history
- Details of complaints, claims and investigations.
The BDA is owned and run by its members. We are a not-for-profit organisation – all our income is reinvested for the benefit of the profession.

Copyright © 2019 British Dental Association. All rights reserved.

Registered office 64 Wimpole Street London W1G 8YS. Limited by guarantee (14161) England.

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.