

Issue 1

1 March 2018

Research Digest**Contents****Regulation**

- Care Quality Commission. (2017). The state of health care and adult social care in England 2016/17. p3
Available at: http://www.cqc.org.uk/sites/default/files/20171123_stateofcare1617_report.pdf. [Accessed 14 Dec. 2017].
- General Medical Council. (2017). The state of medical education and practice in the UK. Available at: p4
<https://www.gmc-uk.org/publications/somep2017.asp>. [Accessed 14 Dec. 2017].
- Plymouth University Peninsula Schools of Medicine and Dentistry. (2017). Analysis of fitness to practise p6
case data for the General Dental Council. Available at: <https://www.gdc-uk.org/about/what-we-do/research>. [Accessed 13 Dec. 2017].
- Professional Standards Authority. (2017). Categorisation of fitness to practise data. Available at: p7
<https://professionalstandards.org.uk/docs/default-source/publications/research-paper/categorisation-of-fitness-to-practise-data-december-2017.pdf?sfvrsn=4>. [Accessed 16 Jan. 2017].
- Searle, R. H. et al. (2017). Bad apples? Bad barrels? Or bad cellars? Antecedents and processes of p8
professional misconduct in UK Health and Social Care: Insights into sexual misconduct and dishonesty.
Available at: <https://professionalstandards.org.uk/docs/default-source/publications/research-paper/antecedents-and-processes-of-professional-misconduct-in-uk-health-and-social-care.pdf?sfvrsn=12>. [Accessed 29 Jan. 2017].
- Patients**
- Ipsos MORI. (2017). Patient and public survey 2017: Research report prepared for the General Dental p9
Council. Available at: <https://www.gdc-uk.org/about/what-we-do/research>.
- Community Research, on behalf of the General Dental Council. (2017). Dental Recall Survey Research p12
Report. Available at: <https://www.gdc-uk.org/about/what-we-do/research>.
- Community Research, on behalf of the General Dental Council. (2017). Self-assessment complaints p14
mechanism workshop. Available at: <https://www.gdc-uk.org/about/what-we-do/research>.
- Finn, D. *et al.* (2017). The development and implementation of a biopsy safety strategy for oral p15
medicine. *British Dental Journal*, [online] Volume 223, pp.667-673. Available at:
<https://www.nature.com/articles/sj.bdj.2017.885>. [Accessed 13 Dec. 2017].
- Walshaw, E. and Ireland, A. (2017). How practices can facilitate access for the Gypsy traveller p17
community. *British Dental Journal*, [online] Volume 223, pp.607-609. Available at:
<https://www.nature.com/articles/sj.bdj.2017.877>. [Accessed 12 Dec. 2017].

Anwar, H. and Waring, D. (2017). Improving patient safety through a clinical audit spiral: prevention of wrong tooth extraction in orthodontics. *British Dental Journal*, [online] Volume 223, pp.48-52. Available at: <https://www.nature.com/articles/sj.bdj.2017.586>. [Accessed 12 Dec. 2017]. p18

Appleby, J. *et al.* Root causes: quality and inequality in dental health. (2017). Available at: <http://www.qualitywatch.org.uk/dental-health>. [Accessed 12 Dec. 2017]. p20

Standards

Mann, J. and Doshi, M. (2017). An investigation into denture loss in hospitals in Kent, Surrey and Sussex. *British Dental Journal*, [online] Volume 223, pp.435-438. Available at: <https://www.nature.com/articles/sj.bdj.2017.728>. [Accessed 11 Dec. 2017]. p21

Apelian, N. *et al.* (2017). How can we provide person-centred dental care? *British Dental Journal*, [online] Volume 223, pp.419-424. Available at: <https://www.nature.com/articles/sj.bdj.2017.806>. [Accessed 11 Dec. 2017]. p23

Fitness to practise

Neville, P. (2017). Social media and professionalism: a retrospective content analysis of fitness to practise cases heard by the GDC concerning social media complaints. *British Dental Journal*, [online] Volume 223, pp.353-357. Available at: <https://www.nature.com/articles/sj.bdj.2017.765>. [Accessed 12 Dec. 2017]. p24

Forthcoming GDC research

GDC fitness to practise end to end review p25

Refocusing fitness to practise and developing the concept of seriousness in professional regulation p25

GDC registrant survey p25

While the General Dental Council (GDC) has made every effort to ensure that it is reporting valid research, we cannot guarantee the validity of the research presented in this document beyond that generated by the GDC, nor does reporting it imply the GDC's endorsement.

Contact: Research@gdc-uk.org

The state of health care and adult social care in England 2016/17¹

Overview

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. The CQC's State of Care report is based on a quantitative analysis of CQC inspection ratings of almost 29,000 services and providers drawing on other monitoring information including staff and public surveys, and performance and financial data, to understand which factors are most closely associated with quality.

Key findings in primary care dental services

- 10% of providers are inspected each year based on a model of risk and random inspection, as well as inspecting in response to concerns.
- Comprehensive inspections carried out on 1,131 dental practices in 2016/17.
- 88% of dental practices were meeting regulations relating to all five key questions (safe, effective, caring, responsive, well-led).
- The outcomes were consistent with the previous year.
- The regulation relating to good governance was the most often breached: 105 practices required action and the CQC took enforcement action in 16 practices.

Other findings

- **Staffing and recruitment:** NHS Jobs vacancy data showed that the number of vacancies across all NHS settings increased by 16% from March 2015 to March 2017² (during a period when the total number of full-time equivalent (FTE) posts went up by 4%). In the same period, the number of nursing and midwifery vacancies rose by 22% and medical and dental vacancies by 40% (while the number of FTE posts in those roles rose by 1% and 3% respectively).³
- **Person-centred care:** Inspectors saw a domiciliary care agency that had been involved in developing training for support staff, such as GP and dental receptionists, to help them recognise the signs of dementia and better understand any behavioural symptoms that people may have.
- **Community health services:** Most core services were rated as good or as outstanding. Community dental services had the best care with 66% of services rated as good and 22% as outstanding.
- **Primary medical services:** The CQC saw improvement in dental care in England in the last two years: after re-inspecting dental practices where it had taken enforcement action, most had improved.

¹ Care Quality Commission. (2017). The state of health care and adult social care in England 2016/17. Available at: http://www.cqc.org.uk/sites/default/files/20171123_stateofcare1617_report.pdf [Accessed 14 Dec. 2017].

² NHS Digital. (2017). NHS Vacancy Statistics England, February 2015 – March 2017, Provisional Experimental Statistics. Available at: <http://www.digital.nhs.uk/catalogue/PUB30033> [Accessed 14 Dec. 2017].

³ NHS Digital. (2017). NHS Workforce Statistics June 2017, Provisional Statistics. Available at: <http://digital.nhs.uk/catalogue/PUB30075> [Accessed 20 Feb. 2018].

The state of medical education and practice in the UK: 2017 report⁴

The General Medical Council's (GMC) seventh annual report on the state of medical education and practice in the UK sets out an overview of issues that feature prominently in healthcare. It examines the GMC data relating to the changing medical register and explores the patterns of complaints about different groups of doctors.

Key findings

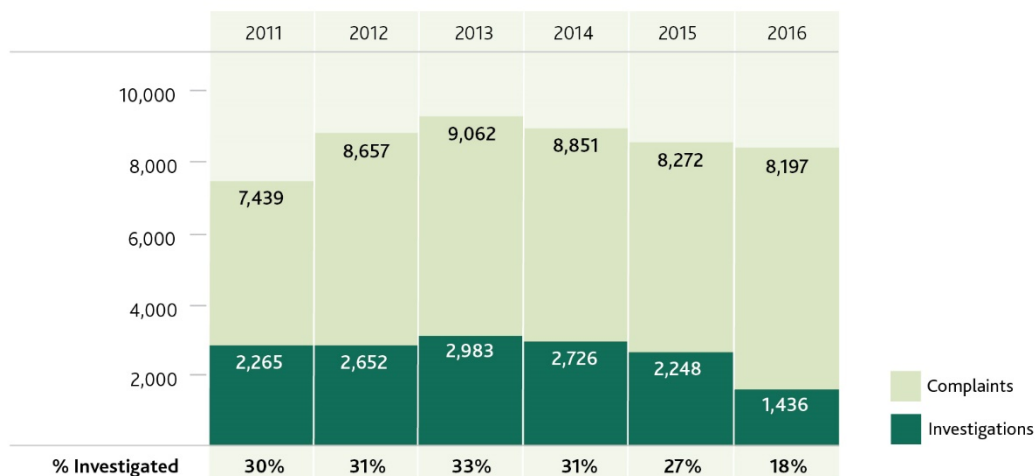
Four warning signs

- The supply of new doctors into the UK medical workforce has not kept pace with changes in demand
- Our dependence on non-UK qualified doctors has increased in some specialties
- The UK is at risk of becoming a less attractive place for overseas doctors to work – both to those already in the UK and those outside it
- The strain on doctors training and being trained continues

Four priorities for workplace planning

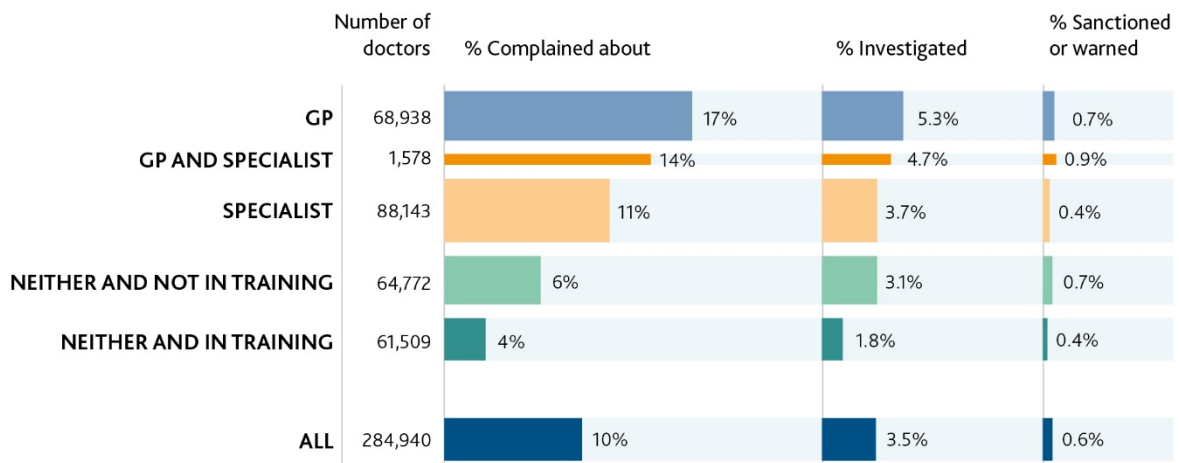
- Maintain a healthy supply of good doctors into UK practice
- Help the UK medical profession to evolve to meet the future needs of patients and healthcare
- Reduce the pressure and burden on doctors wherever possible
- Improve the culture of the workplace, making employment and training more supportive and flexible

All complaints and proportion of which were investigated, from 2011 to 2016

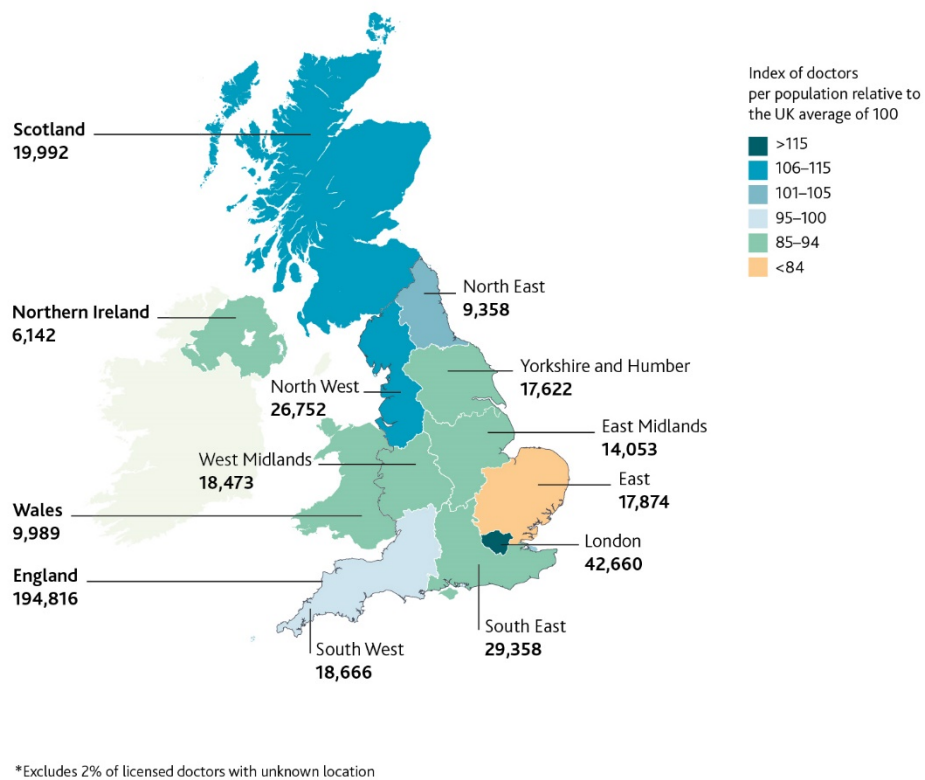


⁴ General Medical Council. (2017). The state of medical education and practice in the UK. Available at: <https://www.gmc-uk.org/publications/somep2017.asp>. [Accessed 14 Dec. 2017].

The proportion of doctors complained about, investigated, and sanctioned or warned, by register, from 2012 to 2016



Number of licensed doctors relative to the population in 2017



All figures reproduced here are copyright of the General Medical Council.

Analysis of General Dental Council fitness to practise case data⁵

Overview

As part of General Dental Council's (GDC) duty to protect the public, if a dentist or dental care professional falls seriously short of the standards expected of them we can either remove them from the Register or restrict what they can do professionally. These powers, given to us by Parliament, cover all registered dentists and dental care professionals whether they are working in the NHS or in private practice.

There may be doubts about a dental professionals' fitness to practise (FtP) due to:

- Health
- Conduct, including convictions and cautions
- Performance

Understanding why complaints are made – who makes them, about what issues, and against which dentists and dental care professionals – is an important element of the GDC's role in protecting patients.

This research aimed to identify trends in the GDC's FtP case data. Such an understanding may provide opportunities for any regulator to move towards becoming a risk-based organisation; proactively seeking to prevent rather than simply being able to respond to complaints and trends of poor practice.

Key findings

- Male dental professionals were more likely than female dental professionals to have been involved in an FtP case
- Dentists were significantly over-represented at all stages of the FtP process, compared to all other registrant groups
- Dentists that came onto the register by taking the Overseas Registration Exam (ORE) were less likely to be involved in an FtP case compared to their UK qualified counterparts
- Dentists coming on to the register having qualified in a European Economic Area (EEA) country were overrepresented in FtP
- The odds of having been involved in an FtP case were 22% higher for dental professionals identifying as 'Asian' or 'Other' compared to those identifying as 'White'. However, it should be noted that there are significant gaps in this data, as it is provided by dental professionals to the GDC on a voluntary basis. The GDC will be considering how to encourage dental professionals to provide voluntary information so any analysis can provide better insight.

⁵ Plymouth University Peninsula Schools of Medicine and Dentistry. (2017). Analysis of fitness to practise case data for the General Dental Council. Available at: <https://www.gdc-uk.org/about/what-we-do/research>. [Accessed 13 Dec. 2017].

Categorisation of fitness to practise data: A description of UK health and care professional regulators' categorisation of fitness to practise allegations⁶

Overview

In order to manage fitness to practise (FtP) cases, all regulatory bodies record the nature of the case or the allegations within a case. This report seeks to understand how this information is recorded and categorised, implications for improving categorisation (including whether greater consistency would be desirable) and using it to support the reduction of harm.

The report:

- Publishes all regulators' category lists for regulators and other organisations to learn from
- Describes possible future uses for the data held in these lists
- Sets out regulators' views on the future of FtP categorisation

Findings

- 7 out of 9 regulators permit more than one category attached to a case. The General Chiropractic Council (GCC) and the General Optical Council (GOC) only attach single categories to a case.
- 6 out of 9 regulators use sub-categories. Sub-categorisation is one way regulators can use data to serve multiple purposes. For example, the Nursing and Midwifery Council (NMC) uses high level simplified categories in 'public reporting', and more detailed lower level categories for 'intelligence'. The need for sub-categories may be determined by how many complaints populate a category.
- The lists of categories of different regulators vary greatly in size. In general, regulators with smaller registers have smaller category lists than regulators with larger registers. For example, the Pharmaceutical Society of Northern Ireland (PSNI) has 3 categories, while the General Pharmaceutical Council (GPhC) has 41 and the General Dental Council (GDC) has 295.
- Only 3 regulators (GMC, GPhC and NMC) mention social media in their category lists.
- 7 regulators have categories that specifically mention honesty or dishonesty.
- Only 2 regulators directly mention 'candour' in their category lists.
- 5 regulators mention 'discrimination' in their category lists.
- 5 regulators have categories specifically for professional indemnity. Only the GDC has more than one category related to indemnity insurance.
- Advertising features across 5 regulators' categories. The GDC has the most exhaustive breakdown of categories related to the subject.
- 3 regulators have categories related to public confidence.
- 2 of the regulators (GDC and NMC) mentioned the potential importance of categories in developing and enhancing feedback loops. A feedback loop is the process by which information collected by a regulator is fed back to registrants in order to improve compliance with standards.
- All but 1 of the regulators responded that more consistency of categorisation across regulators would produce benefits. 1 regulator pointed out a benefit could be that regulators in similar fields can identify common issues and possibly work together on shared solutions.

⁶ Professional Standards Authority. (2017). Categorisation of fitness to practise data. Available at: <https://professionalstandards.org.uk/docs/default-source/publications/research-paper/categorisation-of-fitness-to-practise-data-december-2017.pdf?sfvrsn=4>. [Accessed 16 Jan. 2017].

Bad apples? Bad barrels? Or bad cellars? Antecedents and processes of professional misconduct in UK Health and Social Care: Insights into sexual misconduct and dishonesty⁷

Summary

An analysis of fitness to practise (FtP) cases on acts of professional misconduct from three regulatory bodies – General Medical Council, Nursing and Midwifery Council, and Health and Care Professions Council – was carried out to identify types of perpetrator, and to provide insights into sexual misconduct and dishonesty by health and care professionals.

Key Findings

The research, based on analysis of 6,714 FtP cases, identified three different types of perpetrator:

- the 'bad apple' – the self-serving individual out for personal gain
- the corrupted barrel – individuals corrupted by the failing standards in their workplace
- the depleted barrel – individuals struggling to cope with the pressures of working life

Sexual Misconduct

265 of 6,714 FtP cases were sampled and coded. Of these:

- Most incidents occurred in the workplace (153)
- A higher proportion of incidents were committed by men (230)
 - Doctors: 78 male perpetrators vs 1 female perpetrator
 - Nurses: 96 male perpetrators vs 25 female perpetrators
 - Allied professionals: 56 male perpetrators vs 9 female perpetrators
- Patients were the target in most incidents (151)
- 29.8% were cases from the General Medical Council (GMC)
- 45.7% were cases from the Nursing and Midwifery Council (NMC)
- 24.5% were from the Health and Care Professions Council (HCPC)
- In nearly all incidents, the target was of the opposite sex
- Colleagues targeted were often subordinates/junior
- Incidents of sexual misconduct frequently occurred alongside a charge of 'failure to maintain professional boundaries'

Dishonesty

72 of 1,784 FtP cases were sampled and coded. Of these:

- Most offences occurred in the workplace (61)
- There was an almost even split between male and female perpetrators (34 vs 38)
- The primary target was for self-gain (39); followed by patients (21)
- In most cases, perpetrators acted alone (65)
- Most cases were reported from a source internal to the perpetrator's organisation (38)

⁷ Searle, R. H. *et al.* (2017). Bad apples? Bad barrels? Or bad cellars? Antecedents and processes of professional misconduct in UK Health and Social Care: Insights into sexual misconduct and dishonesty. Available at: <https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/antecedents-and-processes-of-professional-misconduct-in-uk-health-and-social-care.pdf?sfvrsn=8>. [Accessed 29 Jan. 2017].

GDC Patient and Public Survey 2017

Ipsos MORI⁸

The Annual Patient and Public Survey has been carried out by Ipsos MORI for the General Dental Council (GDC) since 2012. The survey is designed to capture patient and public awareness and perceptions of the GDC, and to provide insight into key policy areas.

Satisfaction with dental care or treatment

- 97% - the proportion of patients who visit their dentist at least once a year and are either fairly satisfied (29%) or very satisfied (67%) with their dental care or treatment

Treatment expectations

What factor is most important to dental patients?

Before treatment

- 74% - being told the cost of planned treatment
- 68% - being provided with a description of the planned treatment

During treatment:

- 69% - the hygiene and cleanliness of the dental practice
- 64% - the quality of care provided by the dental professional

Making complaints

- 5% had made a complaint
- 8% of those that had not made a complaint had considered making a complaint
- 48% of those that had made a complaint made their most recent complaint direct to their dental practice
- 31% of those that had made a complaint or considered making a complaint were not sure where to complain
- Impartiality – patients lack confidence in the ability of the practice staff to investigate complaints impartially, which makes them uncomfortable about complaining directly to their dental practice
- 59% of people who have never complained would go online to find out how or where to complain
- 3 in 10 (29%) people would approach the receptionist at their dental practice
- 56% of people who have not complained about a dental professional would not have any concerns about making a complaint
- 14% of those that have not complained would be concerned about making a complaint in case they have to continue seeing the dental professional in future
- 1 in 10 (11%) would be concerned about making a complaint because they would be afraid the practice would refuse to treat them in future
- 61% would want their complaint referred to the right organisation and informed of the referral if they did not complain to the right place
- 28% would want the complaint passed back to them so that they could decide what to do next

⁸ Ipsos MORI. (2017). Patient and public survey 2017: Research report prepared for the General Dental Council. Available at: <https://www.gdc-uk.org/about/what-we-do/research>.

Attitudes to serious misconduct

Patients were asked which sanction they thought would be most appropriate for the GDC to take for each of the examples. The options were: no action; reprimand; conditions; suspension; striking off the register, and; don't know. It was explained that this action was over and above any action that other organisations such as the police may have taken.

Five examples of different types of misconduct were included. These were:

- A dentist accidentally prescribes/a dental nurse accidentally gives the wrong medication to a patient and there are serious side effects leading to the patient being admitted to hospital
- A dentist removes the wrong tooth/a dental nurse reads notes out wrong, as a result, a dentist removes the wrong tooth
- A dentist/dental nurse posts racist comments on their personal Facebook page
- A dentist/dental nurse is charged for drunk and disorderly behaviour on a night out
- A dentist/dental nurse gives a patient a rude response to a complaint the patient has made about them

In general, the public expect more severe action taken when wrongdoing takes place during treatment and involves poor care, as opposed to behaviour in their personal time, if it didn't impact on their work. 42% thought that a dentist who accidentally prescribes the wrong medication leading to serious side effects should be suspended and 21% struck off, with 3% favouring no action.

However, 42% thought that no action should be taken when a dentist is charged by the police for drunk and disorderly behaviour on a night out with 13% saying that they should be suspended and 6% struck off.

However, some behaviour in personal time was viewed differently with public attitudes more divided. About half thought that a dentist should be struck off the register (19%) or suspended (28%) for posting racist comments on their Facebook page, while four in ten thought a reprimand (26%) or no action should be taken (13%).

The qualitative research allowed the reasons behind choice to be explored in more depth. For the Facebook example, some thought that racism would affect a professional's ability to treat patients fairly and would undermine public trust, while others felt that Facebook was a private space and that less severe action such as a reprimand or no action was more appropriate. Some felt that involvement in illegal activity could affect public trust in the individual professionals and the profession as a whole.

The research found that the public tended to treat dental nurses more leniently than dentists. For example, 56% thought they should receive a reprimand for a rude response to a patient complaint about them. 52% thought that would be appropriate for the dentist. The qualitative research found that this was driven by a view, for some patients, that sanctions should reflect the responsibility and seniority of the dentist. For other patients, all dental professionals should adhere to standards and the sanction should reflect the seriousness of the misconduct.

Visiting the dentist

- 54% visited a dentist in the last six months
- 69% went to a dentist within the last 12 months
- 8 in 10 (79%) visited a dentist within the last 2 years
- 2% have never been to a dentist
- 4 in 10 (41%) patients have been with their dentist for 5 years or less

Private vs. NHS Care

- 7 in 10 (68%) patients received NHS treatment *only* during their last visit to the dentist
- 2 in 10 (18%) patients received private dental care only

Awareness of, and confidence in, regulation

- 24% - proportion of the public who say they have *definitely* heard of the GDC
- 83% - those aware of the GDC who are either very confident (20%) or fairly confident (62%) that the GDC is regulating dental professionals effectively. 10% were either not very confident (9%) or not confident at all (1%).

Dental Recall Survey Research Report⁹

According to National Institute for Health and Care Excellence (NICE) guidance, the intervals between oral health reviews should be tailored for individual patients and there is no clinical evidence that, for adults in good health, reviews more often than every two years are clinically effective.

The General Dental Council (GDC), together with NICE and NHS England, wanted to obtain some data on current patient experience relating to recall i.e. how frequently oral health reviews are typically scheduled.

A short online survey was conducted with the GDC's Word of Mouth Panel.

- In total 750 panellists completed the survey between 10-19th April 2017.
- They were asked for their spontaneous views and then shown a Healthwatch video clip which gave information about the NICE guidelines in a user-friendly and balanced way.

Findings

Reasons for going to the dentist for a check-up

- 36% - to spot any problems early
- 29% - to reassure them their teeth and mouths are ok
- 13% - to find out if they need treatment
- 10% - because it is what they are used to
- 9% - because the dentist asks them to
- 2% - to get advice on how to improve their teeth
- 1% - other

Response to dentist suggesting a gap of up to two years between check-ups

- 39% - pleased the dentist thinks my teeth are ok
- 37% - worried something may go wrong with my teeth before then
- 33% - glad to save the time and money
- 25% - pleased not to have to think about going to the dentist for some time
- 17% - confused because I've always seen the dentist more often
- 7% - worried the dentist may forget to see me again
- 6% - other/none of the above

Feeling comfortable asking for a longer gap than six months between check-ups

- 59% - yes, would feel comfortable (of these, those who had dental check-ups less frequently were more likely to say yes, as well as those who described their dental health as 'very good')
- 29% - no, would not feel comfortable
- 90% - comfortable asking for 9-month gap
- 81% - comfortable asking for 12-month gap
- 27% - comfortable asking for 24-month gap
- 49% uncomfortable asking for a 24-month gap, particularly those aged 55+

⁹ Community Research, on behalf of the General Dental Council. (2017). Dental Recall Survey Research Report. Available at: <https://www.gdc-uk.org/about/what-we-do/research>.

After watching the Healthwatch video clip

- 12% increase in those comfortable asking for a longer gap than 6 months
- 2% increase in those comfortable asking for 9-month gap
- 5% increase in those comfortable asking for 12-month gap
- 12% increase in those feeling comfortable asking for a 24-month gap
- However, 18% of people aged 55+ remained very uncomfortable with a 24-month gap (only 3% less than before)

Patient views on complaint handling in dentistry¹⁰

The General Dental Council (GDC) commissioned a workshop with dental patients to explore their views on complaint handling by the dental profession.

Findings

Features of an ideal complaints process

- Includes a self-filtering mechanism
- Follows a nationally standardised procedure, with an online template or form to submit to the local practice via the GDC
- Information about how to make a complaint, and what the procedure will be, is provided locally and displayed prominently
- Patients are reassured that their complaint will be taken seriously
- Local resolution leads to positive outcomes, such as practice improvement
- There is a clear distinction between NHS and private practices
- There is a visual guide to the process – but not an animation or video
- The process is clear, simple and informal as possible

What makes for a good complaints procedure?

- Continuity – records are available to different complaint handlers to avoid the patient having to repeat / reexplain their complaint
- Impartiality / independence – a preference to make a complaint to a separate body
- Responsiveness – patients receive acknowledgement of their complaint, preferably personalised
- Information – patients are provided with the information they need, including what to expect of the procedure
- Clear timeframes for resolution – patients are informed of the expected timeline, are kept up to date throughout, and a timely resolution is aimed for
- A sense of being taken seriously – patients are reassured that their complaint is being taken seriously

Barriers / triggers to local resolution

- Lack of impartiality – perception of bias from dental practice towards dental professional
- Fear of confrontation – preference to complain via a third party
- Fear of repercussions – concern that a complaint would lead to unfavourable treatment
- To 'formalise' the complaint – escalating a complaint was perceived to ensure it would be taken seriously, as well as an opportunity to prevent future mistakes
- A last resort – feeling of being forced to escalate a complaint if local resolution did not appear to be an option, or if a rapid resolution was needed
- Lack of knowledge – not knowing how to raise a complaint at the local level

¹⁰ Community Research, on behalf of the General Dental Council. (2017). Self-assessment complaints mechanism workshop. Available at: <https://www.gdc-uk.org/about/what-we-do/research>.

The development and implementation of a biopsy safety strategy for oral medicine¹¹

Overview

There is potential for errors throughout the biopsy pathway and these can impact on the safe and effective management of patients. The development of a biopsy surgical safety strategy is aimed at encouraging other clinical teams to re-assess their own local procedures and pathways.

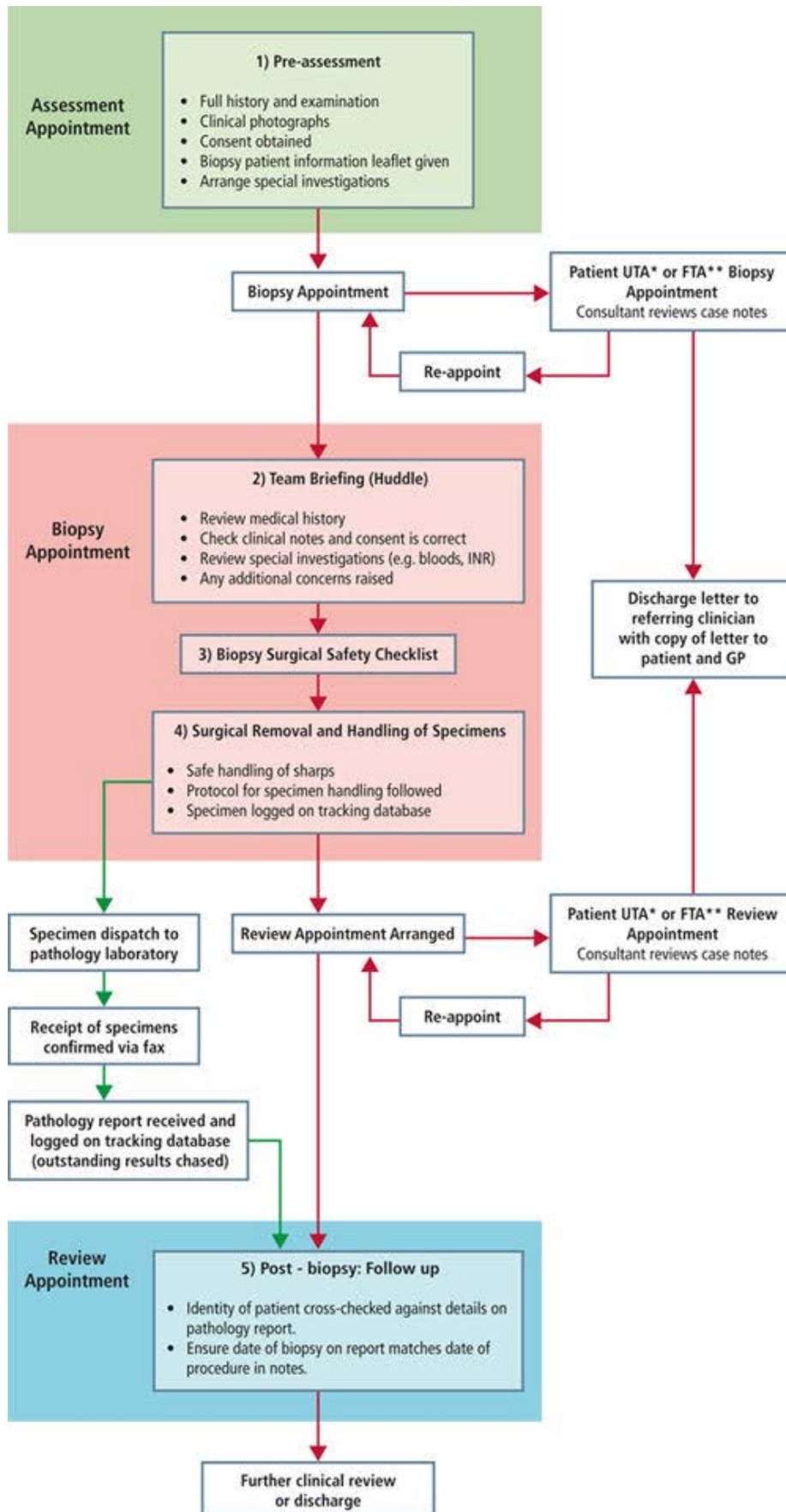
The biopsy safety strategy is based on established practice and the development and implementation of new measures to mitigate the possibility of patient safety incidents. This is divided into five stages:

- Preoperative assessment of patient and procedure
- Team briefings
- Biopsy surgical safety checklist (BSSC)
- Surgical removal and handling of biopsy specimens
- Post-biopsy follow-up

The final strategy is summarised in Figure 1.

¹¹ Finn, D. et al. (2017). The development and implementation of a biopsy safety strategy for oral medicine. British Dental Journal, [online] Volume 223, pp.667-673. Available at: <https://www.nature.com/articles/sj.bdj.2017.885>. [Accessed 13 Dec. 2017].

Figure 1: Biopsy safety strategy: Flow diagram



*Unable to Attend. **Failed to Attend

How practices can facilitate access for the Gypsy traveller community¹²

Aim

- To provide dental professionals with more awareness about the traveller community
- To provide tips on how to communicate and treat this community more effectively in a primary care setting
- To highlight health inequalities in the traveller community and discuss reasons why these exist

Key Findings

- Gypsy travellers have poor health in comparison to the UK average
- Barriers to engaging with healthcare include: a mistrust in health services and personnel; mobile lifestyles; transgenerational fear inhibiting current patients from taking advantage of treatments offered to them, and; cultural barriers, including the normalisation of ill health and pride in self-reliance
- It is estimated that 90% of the community is illiterate

Effective engagement with the Gypsy traveller community				
Consider using verbal methods of appointment reminders	Be flexible with appointment timings	Highlight 'cosmetic' benefits of completing treatment plans	Discuss improvements in the safety of treatments, such as sedation	Arrange exam opportunities after pain appointments
<i>Practice-based training about the needs of this community would be valuable, to ensure the whole dental team are aware of the need for flexibility.</i>				

¹² Walshaw, E. and Ireland, A. (2017). How practices can facilitate access for the Gypsy traveller community. British Dental Journal, [online] Volume 223, pp.607-609. Available at: <https://www.nature.com/articles/sj.bdj.2017.877>. [Accessed 12 Dec. 2017].

Improving patient safety through a clinical audit spiral: prevention of wrong tooth extraction in orthodontics¹³

Aim

To examine compliance with the standards for accuracy and clarity of extraction letters and the incidence of wrong tooth extractions, and to increase awareness of the errors that can occur with extraction letters and of the current guidelines.

Key Findings

- The audit spiral demonstrates the importance of long term re-audit to aim to achieve excellence in clinical care
- There was a gradual increase in standards (accuracy, clarity, and overall gold standards) through each audit
- A consistent approach to documenting teeth for extraction eliminates potential areas of confusion between clinicians

Wrong-site tooth extraction

- The most common reason for patients filing medico-legal claims within orthodontics
- Most cases are preventable
- Linked to poor or miscommunication between colleagues
- 138 claims received by the Dental Defence Union (DDU) between 2006 and 2011, with instances increasing
- Financial cost of settling 56 claims was over £413,000

Guidance

- British Orthodontic Society: clear and accurate communication between healthcare professionals¹⁴
- DDU: clear and accurate communication between healthcare professionals¹⁵
- NHS England: wrong-site tooth extraction is a 'never event'¹⁶
- Care Quality Commission: duty of candour to report wrong-site tooth extraction¹⁷

¹³ Anwar, H. and Waring, D. (2017). Improving patient safety through a clinical audit spiral: prevention of wrong tooth extraction in orthodontics. *British Dental Journal*, [online] Volume 223, pp.48-52. Available at: <https://www.nature.com/articles/sj.bdj.2017.586>. [Accessed 12 Dec. 2017].

¹⁴ British Orthodontic Society. (2001). Advice Sheet 12: Orthodontic extractions risk management guidelines.

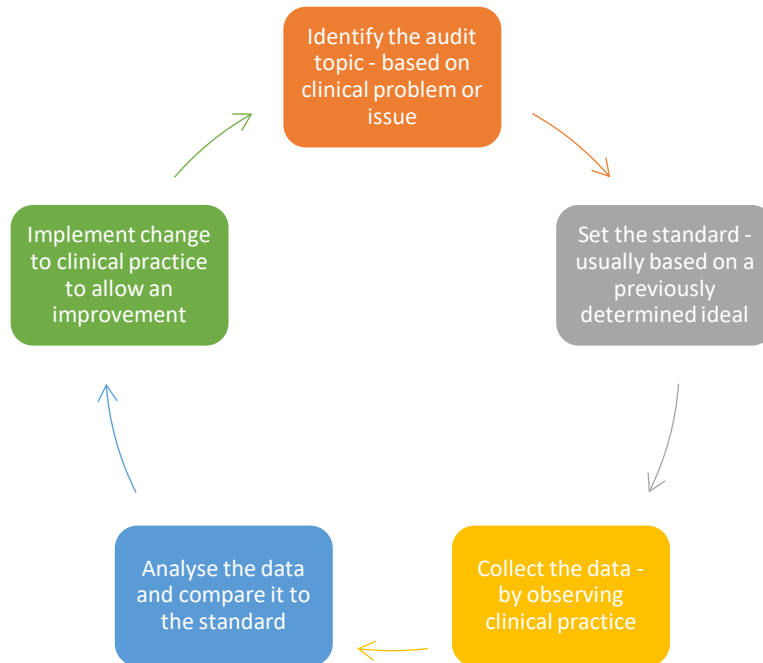
¹⁵ Dental Defence Union. (2013). Rise in extraction error claims reports DDU. Available at: <https://www.theddu.com/press-centre/press-releases/rise-in-extraction-error-claims-reports-ddu>. [Accessed 12 Dec. 2017].

¹⁶ NHS England. (2015). Never Events List 2015/16. Available at: <https://www.england.nhs.uk/wp-content/uploads/2015/03/never-evnts-list-15-16.pdf>. [Accessed 12 Dec. 2017].

¹⁷ Care Quality Commission. (2015). Regulation 20: Duty of candour. Available at: http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf. [Accessed 12 Dec. 2017].

Clinical audit cycle

The process of clinical audit can only become effective once the cycle is repeated, following implementation of recommendations with aims to improve clinical practice. Over a period of time, as the cycle is repeated, the process becomes a 'clinical audit spiral'.



Root causes: quality and inequality in dental health¹⁸

Overview

- This report analyses data on dental health outcomes and activity. It draws on a variety of data to describe the evolution of the service and to show how quality has changed over time.
- The data mainly relates to England, but in some cases, is applied to the UK or other UK countries.

Key Findings

- Overall, dental health has been improving over time: the proportion of adults without any natural teeth has reached an all-time low; the proportion of young children with tooth decay has been steadily falling; and satisfaction with dentistry remains high. But there is significant variation within this.
- Children in the Blackburn with Darwen local authority area were four times more likely to have missing, decayed or filled teeth than children in South Gloucestershire in 2015: just 44% of children in Blackburn were free from decay compared with 86% in South Gloucestershire.
- In Yorkshire, hospitalisation for tooth extractions among those aged under 10 years old was five times higher than in the east of England in 2015/16 (845 per 100,000 population compared to 160 per 100,000).
- 83% of 5-year-olds in the least deprived areas of the country had healthy teeth in 2014/15, compared to 70% in the most deprived areas.
- People from the most deprived backgrounds were twice as likely (14%) to be hospitalised for dental work than those that were better off (7%) in 2015.
- 18% of parents with children eligible for free school meals found it difficult to find an NHS dentist in 2013, compared with 11% of parents whose children were not.

¹⁸ Appleby, J. et al. Root causes: quality and inequality in dental health. (2017). Available at: <http://www.qualitywatch.org.uk/dental-health>. [Accessed 12 Dec. 2017].

An investigation into denture loss in hospitals in Kent, Surrey and Sussex¹⁹

Aim

To identify the reported number of dentures lost in hospitals and the financial reimbursements given by trusts to replace them.

Key Findings

- 695 – total number of dentures lost within 11 trusts over five years.
 - Range = 20-218; Average = 63 per trust
- £357,672 – total reimbursements made by seven trusts over six years.
 - Average = £51,096 per trust

Impact on patients

- Difficulty eating → nutritional impact → more bed days
 - Losing a denture in hospital can have a profound effect on a person. They may struggle to eat without their denture, impacting on their nutritional status which consequently may keep them in hospital for longer.
- Prosthodontic privacy – some people wish to hide the fact that they wear dentures from their family and friends.
- If a new denture is remade the patient may struggle to adapt, following the use of their existing set for years.
- It appears those who receive a replacement or compensation are more likely to do so if they have someone to speak on their behalf.
- The construction of a new denture can take several weeks or months; more if the patient remains in hospital and there is no access to dental care.
- Once discharged, if the patient is immobile or has severe medical problems, they are likely to require hospital transport to appointments or domiciliary visits with increased associated costs.
- Many patients are discharged from acute hospital into community care where there may be dental access issues.

Methods to reduce denture loss

1. Staff training – to be vigilant for dentures
2. Dentures pots – labelled denture pots with lids should be supplied
3. Denture labelling – should be standard practice at the manufacture
4. Raising awareness among patients and families – on common reasons for denture loss

Methods to manage financial implications of denture loss

- Changes could include:
 - an agreed maximum amount to be paid out for a lost denture
 - a thorough investigation into why the denture was lost, to ensure it is in fact the trust's responsibility to financially reimburse.

¹⁹ Mann, J. and Doshi, M. (2017). An investigation into denture loss in hospitals in Kent, Surrey and Sussex. British Dental Journal, [online] Volume 223, pp.435-438. Available at: <https://www.nature.com/articles/sj.bdj.2017.728>. [Accessed 11 Dec. 2017].

Methods to manage patient care when a denture is lost

- An ideal care pathway to ensure the management of a patient after they have suffered denture loss would aim to help all patients have a fair chance to move efficiently towards a positive outcome.
- It should be determined how the patient will obtain a replacement – whether while in hospital, if possible, or from their own dentist.

How can we provide person-centred dental care? ²⁰

Aim

To provide a person-centred dental clinical approach as an applied framework to support dentists who are willing to adopt a person-centred approach to oral care.

Summary

- The presented approach provides a rich opportunity for dentists to fine tune their own clinical approach in order to keep up with the upcoming expectations of their patients.
- The approach is guided by three principles: *humility*, *hospitality* and *mindfulness*.
- The approach consists of four processes: connecting, examining, sharing and intervening.
- Patient-centred approaches in medicine seem to lead to better outcomes, including patient and practitioner satisfaction.
- Studies in medicine have shown that patient-centred approaches do not necessarily take more time.

The person-centred dental encounter				
Guiding principles	Process	Method	Objective	Dentist's attitude
<i>Humility</i>	Connect	Conversation Validation	Understand one another Build relationship	Warm Positive Non-judgemental
	Examine*	Visual Radiographic Tests Interview	Gather data Diagnose	Objective Thorough
<i>Hospitality</i>	Share*	Presentation Discussion	Share explanatory models Understand one another Address uncertainty	Clear Inviting questions
	Decide*	Discussion Negotiation	Co-determine the problem list Co-author a treatment plan	Sharing power Creative
<i>Mindfulness</i>	Intervene*	Non-Surgical Surgical Homecare Lifestyle	Address all illness and disease Heal	Respectful Alliance forming
*Connect is also an element of this step				

For GDC guidance on this topic, see the *Standards for the Dental Team* Principle One: Put patients' interests first.²¹

²⁰ Apelian, N. et al. (2017). How can we provide person-centred dental care? *British Dental Journal*, [online] Volume 223, pp.419-424. Available at: <https://www.nature.com/articles/sj.bdj.2017.806>. [Accessed 11 Dec. 2017].

²¹ General Dental Council. (2013). *Standards for the Dental Team*. Available at: <https://www.gdc-uk.org/api/files/NEW%20Standards%20for%20the%20Dental%20Team.pdf>. [Accessed 11 Dec. 2017].

Social media and professionalism: a retrospective content analysis of fitness to practise cases heard by the GDC concerning social media complaints²²

Aim

- This study explored the prevalence of social media related fitness to practise (FtP) cases investigated by the General Dental Council (GDC) from 1 September 2013 to 21 June 2016.

Key Findings

- 2.4% of FtP cases were related to breaches of the social media guidelines²³
- All the cases investigated were proven and upheld
- Most of the complaints were made against Dental Nurses
- The most common type of complaint was inappropriate Facebook comments

Recommendations

- Dental educators should consider social media activity as another aspect of professionalism and incorporate social media awareness training as part of its overall programme of teaching professionalism
- The GDC should encourage social media training as part of lifelong learning and continued professional development of its registrants

Description of complaints involving Facebook, including hearing outcome	
Brief description of case	Hearing outcome
Registrant published patient name and treatment details on social networking sites and website. Registrant published derogatory comments about three dental colleagues on a website.	Suspension for 12 months with review and immediate suspension.
Registrant asked a patient if he could look her up on Facebook.	Conditions revoked and suspension for 12 months with a review hearing. Immediate order of suspension.
Registrant issued a post on Facebook that was considered 'unprofessional', 'offensive' and 'inflammatory'.	FtP impaired, reprimand issued for 12 months, put on record.
Registrant's comment on Facebook in response to Daily Mail newspaper article with the title 'Muslim staff escape NHS hygiene rule'. Deemed to be 'offensive' and 'unprofessional', content 'deemed inappropriate for publication on website'.	FtP impaired, reprimand issued for 12 months, put on record.
As above.	FtP impaired, reprimand issued for 12 months.
Registrant advertised laser treatment on Facebook page.	Suspension for 12 months with review and immediate suspension.

GDC fitness to practise end to end review

²² Neville, P. (2017). Social media and professionalism: a retrospective content analysis of fitness to practise cases heard by the GDC concerning social media complaints. British Dental Journal, [online] Volume 223, pp.353-357. Available at: <https://www.nature.com/articles/sj.bdj.2017.765>. [Accessed 12 Dec. 2017].

²³ General Dental Council. (2016). Guidance on using social media. Available at: <https://www.gdc-uk.org/api/files/Guidance%20on%20using%20social%20media.pdf>. [Accessed 12 Dec. 2017].

The GDC is carrying out an end to end review of its fitness to practise (FtP) processes. The purpose of the review is to identify ways in which the FtP process can be made more proportionate, efficient and cost-effective, and be used to promote learning.

Research is being carried out with patients and registrants who have been through the FtP process which explores their experience of the FtP process and how that matches with their expectations of a proportionate and fair process. Depth interviews are taking place in December 2017 and early January 2018 as well as a facilitated online discussion group with participants in the telephone interviews. A report analysing the key findings from the research will be available in February 2018.

Refocusing fitness to practise and developing the concept of seriousness in professional regulation

In *Shifting the balance*²⁴, published in January 2017, the GDC set out its agenda for reforming the way we regulate the dental professions. A key element of this proposal was refocusing fitness to practise to ensure that we are using our enforcement powers only in those cases that are sufficiently serious, and which raise questions of patient safety or public confidence in dental services.

The first stage of this work involves developing a firm evidence base for policy development in this area through a programme of research. Research about serious misconduct and sanctions has been carried out as part of the GDC patient and public survey (see page 8 of this digest) and is included in the registrant survey which is currently being carried out (see below).

A literature review is being carried out by Plymouth University Peninsula Schools of Medicine and Dentistry. This will establish, review and summarise all the available evidence and literature about how regulators use their fitness to practise powers and processes to sanction serious misconduct when professionals do not meet the required standards. The literature review report will be available in February 2018.

GDC Registrant Survey

The GDC Registrant Survey comprises two elements: a representative survey of Dentists and Dental Care Professionals across the four nations of the UK; and qualitative research via a set of focus groups and telephone interviews which will allow for an in-depth exploration of the issues.

The survey includes questions on the following areas:

- Perceptions about the GDC
- Communicating with the GDC
- Feedback from patients
- Dealing with patient complaints
- Attitudes to serious misconduct

The representative survey is completed. The fieldwork for the qualitative research is scheduled to be carried out in February and March 2018, with a research report presenting the findings expected in April 2018.

²⁴ General Dental Council. (2017). *Shifting the balance: a better, fairer system of dental regulation*. Available at: <https://www.gdc-uk.org/api/files/Shifting%20the%20Balance.pdf>. [Accessed 24 Jan. 2018].