16th November 2016

Briefing for Joint Nottingham City and Nottinghamshire County Health Scrutiny Committee

Update in respect of Daybrook Dental Practice / Mr D'Mello.

Presented by: Dr Ken Deacon, Medical Director, NHS England (North Midlands)

1. Introduction
2. Background
3. Regulatory Action
4. Patient Screening Exercise
5. Contract Review
6. Lessons Learned and changes made.
    a. Whistleblowing
    b. Identification of Poor Practice
    c. Infection Control

1. <u>Introduction</u>

- This report is to provide an update to members of the committee in respect of Daybrook Dental Practice / Mr Desmond D'Mello.
- Dr Doug Black, formerly Medical Director of NHS England (Derbyshire and Nottinghamshire) provided a report to the committee in December 2014.
- This report intends to provide a summary, and overview of events since Dr Black's previous report, rather than to repeat significant parts of the previous report.

2. <u>Background</u>

- Mr D'Mello worked at Daybrook Dental Practice.
- There had been a number of concerns about his clinical performance over a period of time.
- These concerns were dealt with through the PCT processes which existed at the time; Mr D'Mello usually made the changes required of him to address the performance concerns at the time. Until 2014 these concerns never reached a threshold for either a consideration of removing his contract, nor to remove him from the Dental Performers List.
- In July 2013 a referral was made from NHS England to the national clinical assessment service, for a detailed assessment of his practice. This referral was accepted, and the preliminary case conference took place in September 2013.
- On 27th November 2013 the CQC inspected the practice, and found the practice to be compliant with all standards met except 'Assessing and monitoring the quality of service provision. Specifically the standards relating to infection control were met.
- In February 2014, NCAS carried out their assessment of Mr D'Mello's practice. Although some areas for improvement were identified, these did not relate to infection control practices.
- In June 2014 a member of practice staff (acting as a whistle-blower) provided NHS England with evidence suggesting serious failings in respect of infection control practices.

- NHS England suspended Mr D'Mello from the Dental Performers List immediately, and the General Dental Council (GDC) imposed an interim suspension from August 2014.
- Subsequently a large public information and patient testing exercise has taken place.
- Mr D'Mello has been removed from the Dental Performers List, and subsequently the GDC dental register.

3. Regulatory Action

- Dr D'Mello was suspended from the Dental Performers List in June 2014, when the allegations from the whistle-blower were received. This action prevented him from working as an NHS dentist.
- He was suspended by the GDC in August 2014. This action prevented him from working as a dentist (NHS or private) in the UK.
- He was removed from the Dental Performers list by NHS England in September 2015
- He was erased from the dental registered by the GDC in August 2016.
- At the same hearing the GDC found significant failings and misconduct on the part of a dental nurse also working at the practice, and imposed conditions on her continued registration.

Both NHS England and the GDC, in their cases, placed great weight on the previous assessments of Mr D'Mello's practice, and how these contrasted with the evidence provided by the whistle-blower. During the CQC inspection in November 2013, and during his NCAS assessment, Mr D'Mello was able to demonstrate understanding of and ability to comply with the relevant infection control standards. Effectively both bodies concluded that:

- Mr D'Mello understood what is required of a dentist, and was capable of meeting these requirements.
- But wilfully chose not to do so when not observed.

4. Patient Screening Exercise

- Since 2006 patient registration was abolished, as part of dental contract changes.
- This means records can only be kept for a limited time after a patient's last treatment.
- Which meant accurately identifying all patients treated by Mr D'Mello was impossible
- Therefore a nationwide media announcement was made to encourage testing for blood borne viruses.
- 12000 households were sent letters, where there was a record of somebody at that address being previously treated at the practice.
- Around 4500 patients were tested for blood borne viruses
- There were no newly diagnosed cases of Hepatitis B or HIV
- There were 5 newly diagnosed cases of Hepatitis C.
- 5 undiagnosed cases in a population of 4500 is very similar to the unknown diagnosis rate expected in the wider population. In other words, the rate of people who had Hepatitis C but did not know they had it, was the same as would be expected in this number of people, even had they been picked at random. It is impossible to prove or disprove a causal link to the dental treatment provided.

5. Contract Review

- The dental contract differs from the General Practice Contract. The GP contract is based on a capitation payment for each patient registered with the practice. In contrast, the dental contract is based on Units of Dental Activity (UDAs).
- Provided a practice fulfils the number of UDAs in its contract, there is no simple legal mechanism to reduce the number of UDAs.
- The contract relates to the whole practice, and how the practice distributes the UDAs between different practitioners (and indeed how many they employ) is a matter for the contract holder to decide.
- The number of UDAs allocated to practices was determined during a 'reference period' in 2005; existing practices were allocated a number of UDAs. Practices can voluntarily rescind some of their allocation, or it can be reduced if they are failing to deliver the contracted activity. It is otherwise not usually possible to reduce the number of UDAs without the agreement of the contract holder.
- Based on the reference period Mr D'Mello was given a contract for around 30000 UDA. At the outset of the contract there were 3 dentists employed at the practice, but at the time of the whistle-blower's allegations only 2.

- One of the concerns arising from the investigations into Mr D'Mello's conduct is whether a high UDA level should have alerted the system to the risk of poor practice.
- This concern prompted a review of 'high UDA' contracts.
- Mr D'Mello's contract was the 21st largest (of 296) in Derbyshire and Nottinghamshire.
- There is no formal guidance as to an appropriate number of UDAs per dentist.
- A reasonable workload will obviously vary according to whether practitioners are full time or part time, and the amount of private practice carried out in addition to the NHS work.
- A review of high UDA contracts took place, and did not identify specific concerns relating to contract size.
- An analysis was also carried out into the UDA levels held by dentists who had been referred into the Performance Advisory Group of NHS England (the first stage of the formal performance management process) or to the GDC.
- No correlation was identified between a practice's UDA per dentist level, and the chance of performance concerns leading to referral to either PAG or the GDC.

6. <u>Lessons learned and changes made</u>.

<u>6a. Whistleblowing</u>

At the time this incident arose, NHS England were not a prescribed person as defined by the relevant legislation.

NHS England though did try to protect the confidentiality of the whistle-blower, accepting that there was no formal process in place.

Unfortunately the GDC did inadvertently breach the confidentiality of the whistle-blower.

In April 2016 NHS England became a prescribed person for whistle-blowers under the Public Interest Disclosures Act, and so now has more formalised procedures for dealing with concerns raised by whistle-blowers. This does give additional protections to the individuals concerned.

<u>6b. Identification of Poor Practice</u>

There was an unusual combination of events here, which were very different from the performance problems we usually see.

In normal circumstances when concerns about performance:

- The majority of practitioners are trying to do a good job
- Sometimes they cannot, for a variety of reasons.
- If they have insight and are supported they will often improve.
- Usually assessments of practice and capability are reliable – and give a good reflection of the individual's capability.
- Other members of staff often act as a 'safety net'. If one practitioner is having difficulties, others will either support them, or raise concerns about them.

In this case:

- The dentist was capable of working correctly
- He wilfully chose not to do so, knowing that this would put his patients at risk. (The GDC stated 'Mr D'Mello's knowledge of correct procedure was clearly well established')
- The GDC stated 'Mr D'Mello knew how to achieve compliance with the standards in place and, therefore, his deliberate failure to comply with those standards was particularly egregious behaviour'.
- The dental nurse was aware that what he was doing was unacceptable, and was complicit in it.
- In her evidence to the GDC she reported that Mr D'Mello deliberately suspended cross infection procedures.
- She decided not to report this, as she considered her responsibility to her employer to outweigh that to her patients
- The GDC condemned her action as 'deplorable'

In performance cases (rather than 'misconduct' cases) it is almost unheard of for a clinician to intentionally and systematically provide poor care. In the case of Daybrook a dentist deliberately provided poor care, managed to mislead inspectors and regulators, and the dental nurse colluded with him in this enterprise.

This combination of events means it has been very difficult to extract generalised 'lessons learned from this case.

A number of changes made throughout the system do improve the chances of detecting such behaviour, but it is impossible to completely mitigate against the risk of such a 'rogue dentist' particular if their support staff colludes with them. It is not possible to observe the entirety of any clinicians practice, and behaviour can change when observed.

- The CQC have increased the clinical input into their inspections – there is always a dentist as part of the inspection team. The dentist specifically examines compliance with the Code of Practice for the prevention and control of infections. (This includes discussions with staff, and checking steriliser logs etc.)
- All complaints about doctors and dentists received by NHS England are subject to impartial clinical review; if the reviewer identifies concerns this will trigger referral into the formal performance pathway.

- NHS England becoming a prescribed person for the purposes of the Public Interest Disclosure Act. This opens up a specific avenue for members of staff to report concerns as 'whistle-blowers'
- As part of their inspection regime the CQC ensure that practice staff are familiar with the whistleblowing policies, and serious incident reporting policies.
- The publicity surrounding this case; both in terms of the public information exercise, and the coverage of GDC hearings will have raised the awareness of GDC registrants' responsibilities to raise concerns.

6c. Infection Control

Dental practices are allowed to sterilise their own equipment and instruments. (This is no longer the case for General Practices who carry out minor surgical procedures – who are required to use either single use disposable instruments, or have them cleaned and prepared at a Central Sterile Services Department – CSSD).

It is therefore impossible for an external regulator to gain complete assurance that sterilisation processes are fully complied with.

- Practices provide a self-declaration that they comply with the standards
- Sterilisers either have a data tracker, or print a 'receipt' to confirm successful operation of the steriliser cycle.
- These records are routinely checked by CQC at inspections, and by NHS England inspectors / investigators as appropriate.

Summary

This was an unusual case, in that a practitioner was knowingly disregarding acceptable standards of practice, and was aided in this endeavour by his dental nurse. It is impossible to completely mitigate the risk of such a case occurring again. Changes to the regulatory system including more clinically focused inspections, and changes to the protections for whistle-blowers and wider awareness do provide some mitigation. There are some theoretical ways in which greater scrutiny could be applied, but all would require changes to national legislation or contract terms.
Work has taken place to check if there was a correlation between UDA values of contracts and the risk of performance issues; no such correlation was identified.

Dr Ken Deacon
NHS England (North Midlands)