I very much welcome the opportunity to provide a written submission of evidence in relation to the amendments made to the Children and Young People (Scotland) Act 2014 and the illustrative draft code of practice.

This submission is based on informal discussions that I have had with my colleagues working in dental and oral health services and children’s services in Dumfries and Galloway and colleagues working in dental and oral health services in other NHS Boards within Scotland.

I would like to highlight that I do appreciate that the Scottish Government must take due regard of the ruling of the Supreme Court and must make amendments to the Act in light of this. However, the Supreme Court ruling has now lead to a high degree of confusion over information sharing both in terms of the Children’s and Young People’s Act and also more generally.

Clearly as is required by legislation consent to share information should be obtained in the majority of cases. However, there are some situations in which obtaining consent is not possible. Now that the duty to share has been removed from the legislation and replaced by a duty to consider sharing in line with the Data Protection Act and other relevant legislation, this is adding to further confusion. Part of the problem in dentistry, and probably in other professions, is related to assessment of the risk of harm and at what level risk of harm allows sharing of data without consent. Unfortunately I don’t think that the illustrative draft code of practice is particularly helpful as it is not overly reader friendly and does appear to be open to interpretation. It also doesn’t appear to be consistent with other sources of information such as the General Dental Councils (GDC) Standards for the Dental Team and some of the reported advice given by Dental Defence Organisations.

My understanding of the spirit of the Children and Young People’s Act is that of a preventative and early intervention approach to maximise the health and wellbeing of children and young people by providing support to families to achieve this. Those working in Dental and Oral Health Services are able to play a key role in supporting this agenda. To allow the act to fulfil its purpose and to allow dental and oral health services to play a key role in this, I think it would be helpful for a dental stakeholder group to be established (if it is not already) to look at developing specific guidance for dental and oral health teams in relation to this Act. Such guidance would be helpful in ensuring dental and oral health teams work in ways that are consistent with the legislation whilst still upholding the spirit of the Act. Involvement of the General Dental Council, Dental Defence Organisations and the Office of the Information Commissioner in the development of any such guidance would be essential to help avoid confusing and inconsistent messages.

I have outlined below some scenarios that do arise in dentistry that it would be helpful for specific dental guidance to consider.

1) Child with Dental Decay
A child presents for a dental examination at a dental practice. During that examination it is identified that they have some small areas of dental decay that require some form of treatment (this could be preventive treatment e.g. fluoride varnish application or active treatment e.g. fillings). At this point the child has no symptoms. Appointments are made for that child to return to have the treatment undertaken. They do not come back to the practice to have this treatment completed. Despite the practice trying to contact the family either by phone/letter they do not see the child again. The dentist is likely to be concerned about the health and wellbeing of the child.

- Does this constitute a scenario in which the dentist could share this information with the Named Person within the context of the current legislation?
- Although the draft illustrative code of practice appears to suggest that perhaps it could be (Inform before Sharing No:13). There does at present, appear to be variation of views as to whether or not this type of scenario would reach the threshold that would be required to allow this to be shared under the Data Protection Act.
- The current General Dental Council (GDC) Standards for the Dental Team in relation to Standard 4 - Maintain and Protect Patients Information - advises in section 4.3:
  - You must only release a patients information without their consent in exceptional circumstances.
- The guidance then provided in the Standards document in relation to risk of harm/abuse advises in section 4.3.3:
  - If you have information that a patient is or could be at risk of significant harm, or you suspect that a patient is a victim of abuse, you must inform the appropriate social care agencies or the police.

This scenario is one in which the sharing of this information could allow supportive steps to be taken in collaboration with the Named Person and child’s family to support this child to maintain their oral health and general wellbeing at an early stage before they become at risk harm.

2) Child with Dental Abscess

A child presents to a dental practice with a dental abscess. They are given a prescription for antibiotics and advised to return for further treatment so that the tooth causing the problem can be treated to prevent further episodes of infection. The child doesn’t return for follow up, despite attempts by the practice to contact the parent.

- Does this constitute a scenario in which the dentist could share this information with the Named Person within the context of the current legislation?
- The impacts for the child are potentially more significant as they have actually experienced pain previously and may do again if this matter is not addressed.
- In some situations it may be appropriate for this information to be shared with social services. However, in some situations it may be that sharing this information with the Named Person could allow a more supportive approach to be taken rather than involving social services straight away which may well cause a significant degree of stress for the family and also increase pressure on very stretched social services.

3) Follow up of children with decay in the Childsmile Programme

Childsmile is the National Oral Health Improvement Programme. One aspect of the Programme involves the application of fluoride varnish every 6 months to prevent/arrest the development of dental decay in children in priority schools. Children are consented into
the programme by their parent/carer. If during the fluoride varnish application the child is identified as having a dental problem a letter is sent home to the parent/carer to advise of this offering support from the Childsmile team. If the child presents the following 6 months with the same or worse scenario they are issued with a second letter, again offering support etc. If however, there is no contact/feedback from the parent and the team are unable to contact the parent to follow this up, naturally there is a level of concern that the needs of this child are for some reason not being met.

- Does this constitute a scenario in which the Childsmile Team could share this information with the Named Person within the context of the current legislation?

Again, this scenario is one in which the sharing of this information could allow supportive steps to be taken in collaboration with the Named Person and child’s family to support this child to maintain their oral health and general wellbeing.

I appreciate that this is a very complex area but I hope the above examples are helpful in illustrating some of the scenarios that arise in dental and oral health services. Provision of specific guidance for the dental team would help support teams play as full a role as possible in supporting the health and wellbeing of our children and young people within the context of the Act and other legislation.