Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against a Dental Practice in County Tyrone

NIPSO Reference: 202000777

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

Issue of complaint

1. The issue of complaint accepted for investigation was:

   Whether the Practice's decision not to offer the patient a National Health Service (NHS) appointment and a referral pathway for care and treatment was reasonable and appropriate.

2. The complainant's son (the patient) sustained an injury to his lateral incisor in January 2020. The patient had a temporary filling applied by a dentist in Dundalk and then attended the Practice on 24 January 2020. According to Practice notes, a treatment plan was agreed at this stage and the patient confirmed that he was not in pain. The patient contacted the Practice in April 2020 and then again in July 2020. The complainant said that, in July 2020 the Practice informed the patient that NHS treatment for the fitting of a permanent crown would not be possible as the patient did not meet the required criteria at that time because of Covid-19 restrictions. The patient attended the Practice on 17 July 2020 for the re-cementing of the temporary crown and then again on 23 July 2020 for post-crown preparation. This appointment and the subsequent fitting of the crown on 7 August 2020 were non-NHS procedures. The complainant said that no appropriate treatment plan was in place, the patient should have been provided with NHS treatment for the fitting of the post-crown and that alternate treatments should have been considered.

3. Specific standards and guidance were identified as relevant to this complaint.

4. The Practice provided the patient's dental records for his appointments during 2020, as well as an explanation of the treatment the patient received.

5. I obtained independent professional advice from a registered dentist (D IPA) with 31 years' experience working within Primary Care Dentistry. I received clinical advice. The IPA advice document incorporated advice related to two issues of complaint but which, to ensure compliance with General Data Protection

legislation, were subject to two separate reports. Therefore any aspects of the IPA advice document not related to the issue of complaint addressed in this report has been redacted.

Responses to the Draft Decision Report

6. Both the complainant and the Practice were given an opportunity to provide comments on the Draft Decision Report. Where appropriate, comments have been reflected in changes to the report. Other comments are outlined below in paragraph 7.

The complainant's response

7. The complainant disputed that the patient was not entitled to NHS treatment at the time of the events which was during the period April to July 2020 in the first four months of the Covid-19 pandemic. She said that due to the location of the tooth and the patient's age, from a *'social acceptance or aesthetic point of view',* he needed to be given timely treatment. The complainant also queried the parameters of the timescales, in relation to the availability of NHS treatment at the time of the Covid-19 pandemic, which she said were cited by the Practice.

Third Party Enquiries

8. I requested information from the HSCB about the two points raised by the complainant, with specific reference to the patient's age and the location of the tooth. The HSCB stated that, due to Covid-19, from March 2020 to 19 July 2020 all practices were required to cease Aerosol Generating Procedures (AGPs) and only urgent non-AGP procedures were permitted. The HSCB stated that any non-urgent or routine treatment was to be postponed. The HSCB stated that '*the provision of a permanent crown would have been deemed to be routine non-urgent treatment*' and therefore did not fall within procedures permitted within the guidance for that period. The HSCB also stated that the guidance during that period was subject to review and update and therefore, timescales for a return to standard operations remained uncertain. The HSCB stated that from 20 July 2020, this treatment would have been permissible, however, the operational guidance issued stated that patients were to be prioritised based on their clinical need with urgent care prioritised over non-urgent care and routine treatment.

The HSCB stated that the implementation of the new requirements would vary from practice to practice, taking into consideration the balance between the practice's capacity to provide treatment and the level of unmet demand. The HSCB stated that, it therefore may not have been possible to provide non-urgent and routine treatment within any particular practice due to insufficient capacity if there were patients with more pressing needs who were required to be prioritised. The HSCB also stated that, after 20 July 2020, the timescales for providing the treatment would continue to remain uncertain as these would also be determined by the capacity of, and demands on, individual practices.

Analysis and Findings

9. In response to enquiries, the HSCB confirmed that under guidance issued to dental practices, the treatment required by the patient was not permitted within the Covid-19 restrictions prior to 20 July 2020. The HSCB also confirmed that, under guidance covering the period post 20 July 2020, dental practices were required to prioritise patients according to urgency of care, taking account of the demands on, and capacity of, individual practices. I note that the HSCB categorised the treatment required by the patient as '*routine'* and *'non-urgent*' treatment, a point confirmed by the D IPA who advised that '*the requested treatment, namely the creation of a new crown for the patient's UR2, was non-urgent'*. The HSCB also indicated that, during the period up to 20 July 2020, timescales for a return to standard operations across dental practices were uncertain and that, after that date, timescales for individual treatments were dependent both on the capacity of any practice and the specific needs of its patients.

10. I have considered and accept the D IPA's advice that the approach to the treatment and the treatment plan formulated on 24 January 2020 was appropriate. The D IPA advised that the treatment sought by the patient from April to July 2020, after the initial treatment in January 2020, should not have taken place under NHS arrangements following guidance issued on the 18 March 2020, a point also made by the HSCB. I consider the treatment provided and what was offered by the Practice up to 20 July 2020 was in line with good dental practice and in accordance with guidance issued on the 18 July 2020 regarding

controlling the risk from Covid-19. Both the D IPA and the HSCB have advised that the treatment required by the patient constituted non-urgent treatment, could only be offered on a non-NHS basis up to 20 July 2020 and that the Practice followed the relevant guidelines. I note in support of the position that the patient's treatment was non-urgent, that the D IPA advised that the patient was not in pain and there was no infection. I also note the Practice's referral, in its correspondence with the patient's mother, to her request that the crown be provided with urgency, ahead of the family holiday and return to school.

11. I note that the Practice stated that, following the change in guidance on the 20 July 2020, it was not in a position to offer a NHS routine appointment at that time and that due to the Covid-19 restrictions in place, it could be '*some months*' before a NHS slot would be available. I note that this uncertainty of timescales reflects the HSCB guidance. I am satisfied that the timescale for the treatment post the change in guidance on the 20 July 2020 was uncertain and that it was for the patient and his mother to determine if they wished to wait for a routine NHS slot to become available.

    The D IPA advised that, from 18 March 2020, all non-essential Aerosol Generating Procedures (AGP) had to cease. I note that this followed the guidance from the HSCB. I therefore accept the D IPA's advice that the delay between the appointment on 24 January 2020 and the treatment actually being carried out was caused by restrictions imposed due to Covid-19.
12. Lastly, I note and accept the IPA's advice that alternative NHS remedies would not have been appropriate.

13. I conclude that the patient received appropriate care and treatment from the Practice during appointments and treatment in 2020. Therefore, I do not uphold the patient's issue of complaint.

MARGARET KELLY
Ombudsman **14 March 2022**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.

- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.