Written evidence submitted by Parliamentary and Health Service Ombudsman (PHSO) (DTY0040)

1. **About the Parliamentary and Health Service Ombudsman**

1.1. The Parliamentary and Health Service Ombudsman (PHSO) provides an independent and impartial complaint handling service for complaints that have not been resolved by the NHS in England and UK Government departments.

1.2. We consider complaints where someone believes there has been injustice or hardship caused because an organisation has not acted properly, has given poor service and not put things right. We share findings from our casework to help Parliament scrutinise public services and drive improvements in service delivery and complaint handling.

1.3. We investigate complaints fairly and independently, and our service is free to use.

1.4. When we look into complaints about the NHS in England, we do so under powers granted by the Health Service Commissioner Act 1993, which allows a member of the public to bring a complaint to PHSO if they are not satisfied with the final response they receive from the organisation they are complaining about.

1.5. The NHS Complaint Standards, which aim to support frontline NHS organisations to handle complaints effectively and use the learning from complaints to improve services, will be embedded across the NHS from March 2023 and used in our casework from April 2023.

2. **Complaints about NHS dentistry**

2.1. PHSO upholds (fully or partly) a higher proportion of dentistry complaints (75%) compared to complaints about all NHS services (60%). This means that we find that things have gone wrong in dental services, and have not yet been put right, in a larger proportion of dentistry complaints than other types of NHS complaints.

2.2. We have analysed all the complaints about NHS dental practices that PHSO has resolved since April 2019, where we found that something had gone wrong and the practice has not resolved it. This submission sets out the key themes in these complaints that ICBs and dental practices can use to learn and improve.

2.3. The most common themes we identified in these complaints are:

- Poor complaint handling by dental practices
- Poor management and updating of patient records following diagnosis and treatment
- Failure to follow established clinical and professional guidelines in diagnosis of dental issues
- Poor communication of treatment options and resulting costs

3. **What role should ICSs play in improving dental services in their local area?**

ICBs should encourage dental practices to learn from complaints

3.1. Complaints offer a valuable source of learning to help improve services for everyone. Good complaint handling is not only about effective processes and systems. It is also about a culture of learning and improvement. As ICBs take on accountability for dentistry commissioning and oversight from April 2023, there is a crucial opportunity to drive good practice in complaint-handling.

3.2. The NHS Complaint Standards set out how organisations providing NHS services should approach complaint handling. They apply to all NHS organisations in England and independent healthcare providers who deliver NHS-funded care.

3.3. The Complaint Standards aim to support organisations in providing a quicker, simpler and more streamlined complaint-handling service with a strong focus on early resolution by empowered and well-trained staff. By creating a just and learning culture with better communication between providers and the public, the NHS Complaint Standards will promote better accountability and openness – and better-quality services that improve by learning from complaints.

3.4. The Complaint Standards were developed by PHSO in partnership with a number of organisations across the health sector in England including regulators, patient advocacy groups, professional bodies and statutory organisations. Since summer 2021, the Complaint Standards have been tested with more than 80 pilot sites and early adopters. This included a dental practice that provides both NHS and private dental care.

3.5. Feedback from the dental practice shows that they have welcomed the opportunity to pilot the Complaint Standards and the support provided from PHSO staff. They referred to the Standards as a tool that provides a strong starting point for improving complaint handling. They said the Standards' emphasis on the importance of communication was helping them to give staff the confidence to address complaints earlier on.

3.6. The Complaint Standards build on and support the requirements of the NHS Constitution, Duty of Candour and the NHS Complaint Regulations. The General Dental Council's six core principles of complaint handling best practice, which were developed by complaint handlers across the dental sector, are one of the underpinning documents of the NHS Complaint Standards.

3.7. ICSs should ensure that the NHS Complaint Standards are embedded in dental practices across their footprint to ensure the learning from safety issues and a quality improvement culture is consistently adopted.

ICBs should reduce delays in referral between dental practices and secondary care

3.8. The first stage of dental contract reforms set out by NHS England in July 2022 state an ambition around 'improving care to high needs patients'. Patients with more complex treatment needs are those most likely to need referral on from their community dentist to specialist treatment.

3.9. In our casework, there are several examples of failures to refer patients from dental practices onto specialist treatment in a timely and appropriate way. This resulted in unnecessary delays in commencing treatment and distress for patients.

3.10. In one case, a patient presented to their dentist with symptoms of a temporomandibular joint, a condition which limits normal jaw movement and causes pain. After recommending a set of exercises, the dentist initiated a referral to a maxillofacial department at a local hospital. The dental practice failed to make this referral for 13 months. Their inaction was identified only when the patient proactively followed-up with the secondary care provider directly, who reported that they had not received a referral.

3.11. On returning to the dental practice, the patient was advised that a referral was still necessary. Again, when no notice of an appointment was received, the patient made a complaint to the dental practice. It was only when this complaint was received that a full

referral was made and the patient was able to receive appropriate treatment to manage their symptoms. This was over 12 months after the attempted first referral.

3.12. In response to this complaint, Practice Management stated that as dentists are effectively self-employed, they bear all responsibility for the treatment they provide including failings to carry out referrals. The Practice has effectively placed the blame for the failure to refer on the dentist. The dentist claims a computer error resulted in the failure to refer and so places responsibility on the Practice. As referrals should be carried out promptly and, wherever possible, on the same day, we found failings in both the referral process on two occasions as well as in the dental practice's complaint handling. The conflicting correspondence from Practice and dentist shows a problematic lack of organisational accountability for referrals.

3.13. Prompt referrals are key to ensure that people who may be in pain, distress or living with unresolved oral health problems, are able to access care in a timely way when they are in most need. In addition, timely referrals also have a key role to play in secondary prevention of oral health issues. It is easier and potentially more cost-effective to treat people at an earlier stage before their condition deteriorates and may become harder to resolve.

3.14. ICBs should hold dental practices accountable for making timely and appropriate onward referrals for specialist treatment where clinically necessary. The role of the ICS as a whole to bring together health services in a particular area, to ensure more joined-up care for the public and to get the most out of collective resources, means they are uniquely placed to ensure that the referral process between services is efficient and seamless.

3.15. ICB oversight of primary, secondary and community dental services must explicitly include managing effective referrals and communication between these services to avoid delays in diagnosis and treatment.

ICBs should address the issue of inappropriate and unnecessary referrals to private care

3.16. In our own casework, we found several examples of patients not being advised of applicable treatment costs particularly when this fell outside of NHS treatment bands, referrals for private treatment without cost implications being properly discussed or private referrals when NHS treatment may have been available and appropriate.

3.17. Referral for private treatment from NHS dentists should be by exception where there is felt to be a clinical need that cannot be met by NHS services. Where private referral is initiated, cost implications must be discussed clearly with the patient at the earliest opportunity and should form the basis of obtaining informed consent for treatment to be carried out. Transparency on the full costs of treatment is essential for a referral to be properly made.

3.18. For example, in one complaint, a dental practice referred a patient for private treatment because the dentist did not feel comfortable in carrying a treatment involving dental pulp themselves. The complainant qualified for free NHS treatment due to an exemption. However, they were charged over £1000 for the root canal treatment. Ordinarily, root treatment would fall under a band two NHS treatment charge, £65.20, or free to a patient with an exemption.

3.19. NHS England states that 'on an individual basis, there may be situations where a clinician believes that their patient's clinical situation is so different to other patients with the same condition that they should have their treatment paid for when other patients would

not'. In these cases, NHS clinicians can ask NHS England for funding for treatment through an 'Individual Funding Request'. ICBs often refer to these cases using the term, 'Clinical Exceptionality'.

3.20. When referring onto the specialist for private treatment, the dentist failed to complete an 'Individual Funding Request' for NHS contribution to the treatment costs. This was on the basis that it was felt the request was more than likely to be rejected and, to do so, would cause further delays when treatment was felt to be needed promptly.

3.21. Dentists are within their rights to refuse to carry out treatment if they do not feel comfortable in delivering it themselves. As specialist treatment may be required urgently, appropriate and fair review of Individual Funding Requests must be a key priority for the ICB in their role of having oversight for dentistry funding and commission.

3.22. Our investigation did not find evidence that the dentist had considered the individual's NHS exemption nor sufficient evidence to justify why a private referral was the most appropriate option for this patient. Only offering the option for a private referral is not in line with standards set out by the General Dental Council. NHS England considered that the treatment required in this case was not complex enough to warrant a referral and found no reason why the treatment could not have been attempted by a general dental practitioner.

3.23. In this case, an inappropriate referral to private care was compounded by the failure to apply for an Individual Funding Request. The failings caused the individual financial loss and considerable distress.

4. How should inequalities in accessing NHS dental services be addressed?

ICBs should play a leading role in removing inappropriate barriers to accessing dental services

4.1. The complaints we receive about NHS dentistry cover a broad range of issues including delayed referrals, the imposing of unnecessary private treatment costs, poor communication of information on the availability of dental services and poor complaint handling. ICBs should take responsibility for ensuring that all barriers to accessing dental services are removed.

4.2. Public Health England's 2021 report, 'Inequalities in oral health in England', states that although the 'pathways between socio-economic disadvantage and poorer oral health are still under researched', it is clear the consequences of poor oral health do 'disproportionately affect the most vulnerable and socially disadvantaged individuals and groups in society'. ICBs must lead the way for urgently removing barriers that disproportionately affect more disadvantaged communities where oral health tends to be poorer.

4.3. One of the core duties of the ICB is their duty to reduce inequalities in access and outcomes from health services. Government guidance on the preparation of integrated care strategies specifies that outcomes also specifically include those around patient experience.

5. Does the NHS dental contract need further reform?

Improving information for patients

5.1. One of the areas of change identified in the first stage of dental reforms (July 2022) focused on 'improving information for patients' by necessitating a more regular updating of the Directory of Services to make it easier for patients find a dental practice.

5.2. As well as requiring individual practices to update details on a quarterly basis, there should also be a requirement for clear and current information on accessing a dentist in an emergency or out of normal service hours.

5.3. From our casework, we know that access to urgent dental care, particularly during the COVID-19 pandemic was problematic for individuals. The issue of dentist closures due to COVID restrictions was compounded by discrepancies in information on where patients could safely access emergency treatment for example through local Dental Hubs.

5.4. In one case, we found that a patient was sent back and forth between individual dental practices and NHS 111 services when they tried to access urgent treatment. They were also told, inaccurately, by the dental practice that their symptoms did not meet the criteria for referral to the next stage of local urgent care urgent system.

5.5. In order to address inequalities in oral health, it is important to make sure that all parts of the community can easily access information about where to turn for dental treatment. This is key from both an equality perspective in terms of accessibility of information but also in supporting people to access treatment at the earliest opportunity possible and reduce the need for more complex or urgent care at a later stage.

5.6. As well as accurate information on what emergency dental treatment is available in a particular area and what constitutes a dental emergency, the correct and most efficient route of referral should also be clearly set-out for patients including the role of dental practices and urgent care services such as NHS 111.

5.7. More broadly, the case cited in *3.18* further highlights the need for complete transparency over the costs of care. This includes, further public facing information about NHS treatment bands, what does and does not meet the criteria for NHS treatment and the options for private referral. The proposed changes to Units of Dental Activity (UDA) in the dental contract reforms should be accompanied with appropriate and accessible patient facing information on treatment entitlement, costs and exemptions.

Personalisation of recall intervals

5.8. The July 2022 Dental Contract changes also announced the personalisation of recall intervals to allow dentists to focus on 'interactions which have the highest clinical value' and where there is greatest patient need. Where greater flexibility around recall intervals for routine dental examinations is permitted, it is vital that decisions around recall are agreed and communicated clearly with patients and that this is documented in patient records.

5.9. We found that poor record keeping by dental practices is a common issue, which compounds the impact of other failings in care. For example, in one case, failing to document an accurate diagnosis led to a lost opportunity for a patient to improve their oral health routine. We found that dental practices had not followed guidelines on good record keeping in line with the Faculty of General Dental Practice.

5.10. With greater dentist discretion around reviewing patients, particularly those who are deemed at lower risk of dental disease, must come a reinforced obligation on dental practices to clearly document agreed recall intervals in patient records.

5.11. In order to not undermine the broader aim of the dental contract, to improve oral health outcomes for all, it is important that the greater flexibility around recalls does not exacerbate existing inequalities in oral health. ICBs and dental practices should ensure that

people at greatest risk of poor oral health are prioritised for review and treatment accordingly.

Jan 2023