The Newcastle-upon-Tyne Hospitals NHS Foundation Trust

RTD

Community dental services

Quality Report

Freeman Hospital, Freeman Road, High Heaton
Newcastle upon Tyne NE7 7DN
Tel: 01912336161
Website: http://www.newcastle-hospitals.org.uk

Date of inspection visit: 19 – 22 January 2016
Date of publication: 06/06/2016

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RTD04	Arthur's Hill Clinic		
RTD04	Kenton Centre		
RTD04	Molineux Street NHS Centre		
RTD04	Walker Centre		

This report describes our judgement of the quality of care provided within this core service by The Newcastle upon Tyne Hospitals NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by The Newcastle upon Tyne Hospitals NHS Foundation Trust and these are brought together to inform our overall judgement of The Newcastle upon Tyne Hospitals NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Good

We rated the community dental services at this trust as good because:

- We considered the service was staffed by people who were trained and regularly appraised and who were willing to learn and improve from any incidents and who showed a real commitment to safeguarding their patients.
- The community dental service had an effective referral based service for the local community, including managing an emergency 'out of hours' service and an oral health promotion team which worked with local schools and other agencies.
- We observed care from caring and committed staff who had chosen to work in a community setting to provide consistently patient focussed and compassionate care.
- The community dental service was responsive to the needs of its patients who often had complex needs, for example those with a learning disability. Staff spoken with saw complaints as a way to improve and shape the service given to patients and could describe how changes had been made to their practice to deliver better care.
- The community dental service was led by a consultant in special care dentistry. The service had robust governance arrangements in place which were evidenced in minutes of meetings seen and reported to the Board through the medical director. Staff were engaged and motivated and spoke proudly about the innovations they had achieved, particularly with regard to the dental student programme which ran throughout the year to provide training for future dentists.

Summary of findings

Background to the service

The Newcastle upon Tyne Hospitals NHS Foundation Trust provides community dental services in four community dental clinics spread across Newcastle. It provides a full range of dental treatment (including conscious sedation) for patients who are residents of Newcastle and who have one of the following characteristics: under eighteen;homeless;an asylum seeker; have mental health problems;have learning difficulties;are medically compromised;have a phobia towards visiting the dentist; or are unable to obtain treatment under the NHS through the general dental services. It provides services Monday to Friday from 9am to 5pm, including home visits. In addition, 'out of hours', the Molineux centre manages an emergency service for patients in Newcastle, North Tyneside and Northumberland.

The community dental service works with the Newcastle Dental Hospital where patients who require a general anaesthetic ('GA') are seen. It also provides dental care for patients who are under the care of the trust's urology or cardiology service. An oral health promotion team is based within the community dental service and this team promotes oral health and works with schools for children with special needs and also at mental health secure units.

A significant feature of the community dental service is the provision of an outreach training programme for fourth and fifth year dental students which runs for the whole year. Dental students, who are supervised by clinical staff, have their own waiting list and there are specific consent forms which patients must complete if they agree to be treated by a dental student.

The community dental service is led by a consultant in special care. The locations are staffed by five senior dental officers, seven clinicians, four senior dental nurses, fourteen dental nurses, seven administrative staff and a oral health promotion team with three staff. In the period May 2014 to October 2015 the community dental service provided 7,956 units of dental activity (units of dental activity are measures of activity used by the NHS dental contract system).

During our inspection we visited the four community dental clinics at:

- Arthur's Hill Clinic
- Kenton Centre
- Molineux Street NHS Centre
- Walker Centre

We also spoke to senior dental officers, senior dental nurses, dental nurses and administrators, two patients and five parents of patients, observed patient care and reviewed 10 patient records. Further, we ran a listening event for the public and received information about the community dental service from focus groups. In addition, prior to and after the inspection, we reviewed data about the community dental service supplied to us by the trust.

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Deputy Chief Inspector, Hospitals, Care Quality Commission

Team Leader: Amanda Stanford, Head of Inspection, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a dentist and a dental nurse.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

Summary of findings

How we carried out this inspection

We inspected this service in January 2016 as part of the comprehensive inspection programme.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit from 19 to 22 January 2016.

What people who use the provider say

During our inspection, to gain an understanding of the patients' experiences of care, we spoke with patients and parents of patients. They said they were very happy with the care and support provided by the staff and were overwhelmingly positive about the care they had received from the staff.

Good practice

- The senior dental officer led on mental health issues and had developed with the trust's mental health team a 'best interests' meeting agenda for use with patients who were unable to provide consent to treatment. Carers, social workers and other health professionals or interested persons were invited to the meeting to input into best interest decisions.
- The service took part in an outreach-training programme for fourth and fifth year students; the programme ran for a whole year rather than a few weeks, which was the only programme of its type in the North East.

The Newcastle-upon-Tyne Hospitals NHS Foundation Trust

Community dental services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because:

- Staff spoken with at all locations understood their role in reporting incidents and knew how to do so and could describe how learning from incidents to improve patient safety had been shared.
- Policies and procedures were in place to safeguard children and adults, including a robust procedure to review those patients that regularly did not attend their appointment. Staff had received safeguarding training which was up to date and staff could describe steps taken to promote safeguarding.
- Medicines (including emergency and controlled medicines) were logged, well-stocked, up to date and stored safely when not in use. All locations visited used reception desks and keypad locks on doors to restrict access to dental service areas to dental patients. Equipment was checked and maintained, including x-ray equipment. Systems were in place with outside contractors to safely dispose of waste.
- All patient dental records were computerised and those seen were legible, detailed and stored securely.
- At each location the environment was visibly clean and tidy, and staff followed infection control measures, including de-contamination and use of personal protective equipment, in order to comply with national guidelines. Audits of cleanliness were regularly carried out.
- Staff were mostly up to date with their mandatory training and staffing levels and skills mix were set to enable staff to safely assess and manage patient risk.

Safety performance

- The safety performance of the community dental service was measured by reviewing the incidents reported at the service. We saw from minutes of meetings supplied by the trust that this occurred at directorate management team meetings, clinical governance meetings, and at senior team meetings.

Incident reporting, learning and improvement

- The community dental service supplied data about incidents at its service to the National Reporting and Learning System, which is overseen by NHS England. In the period 1 October 2014 to 24 November 2015 there had been no 'never' events at the service (never events

are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers). In the same period there were 23 incidents, 19 of which were 'minor' and four of which were 'insignificant'. No themes are apparent although 39% of incidents related to accidents involving staff, such as needlestick injuries. We were told that following such a report the staff member had received additional training to support them in disposing of sharps safely and the induction programme for staff was changed to try and reduce the incidence of such episodes.

- The service lead described how they received monthly reports about incidents which they reviewed and discussed at senior team meetings which were then discussed at local level at team briefs. Staff spoken with knew how to report incidents using the trust's electronic system. Also they were able to describe how they had used incidents to improve the safety of care for their patients and share this learning across the locations using the team brief.
- For example, staff described an incident where a patient reacted badly to a drug and while waiting for an ambulance, staff had to provide emergency treatment. As a result of the incident, and to improve patient safety, it was agreed to leave the oxygen cylinder free of any attachments to enable quicker application of the ambibag and also adrenalin was to be placed with the emergency medicines box held in the surgery, and not just the emergency medicines box held in the treatment bays. This system was observed in use across all locations.
- Another example of learning from incidents concerned the never event in May 2015 at the Newcastle Dental Hospital, which involved the wrong site administration of a drug. As a result, the dental directorate introduced a pre-needle stamp procedure. This involved various checks and balances to ensure the correct drug was administered to the patient at the correct location. This procedure was observed in use at all locations.
- In terms of the duty of candour, one member of staff described an incident where a dental student had carried out repeat x-rays without telling the patient about their error. The patient was told about this. As a result, a radiology report form was created which required more information to be recorded so that the necessity of the x-ray could be confirmed by radiology staff.

Safeguarding

- One of the senior dental officers was appointed as 'safeguarding' lead. At each location there were photographs of the dental team on display to support patients in identifying dental staff and policies for safeguarding children and adults were seen. All staff spoken with carried a card on which were the details of safeguarding leads within the trust. A safeguarding checklist was seen within the surgeries.
- An example of a safeguarding procedure the service used was the 'do not attend' process for patients who failed to attend their appointment. This process recognised that patients who failed to attend appointments might pose a safeguarding risk. The process involved tasking the administration team to populate a 'do not attend' form for patients who failed to attend their appointment. This form was reviewed weekly by the senior staff and decisions were made about whether to escalate concerns to the trust's safeguarding team who would then take the necessary steps to safeguard the patient. One staff member described how they had used the procedure for a patient who did not attend which led to a meeting with another agency which led to the provision of dental care.
- Staff had been trained in safeguarding children or adults and training data supplied by the trust showed that 78% of medical and dental staff were upto date with safeguarding level 1 training against a target of 95%. One staff member described how, when they saw a patient with grossly decayed teeth, they had used their training to alert the trust's safeguarding team.

Medicines

- The community dental service managed its medicines safely.
- At each location the cupboard where drugs were stored was locked and the key for the cupboard was either identifiable within a lockable key cupboard or in a keypad box on the wall next to the drugs cupboard. Passwords for the locks were known only by staff that required access to the drugs cupboard.

Good

Are services safe?

- Medicines seen were logged by batch and expiry date, and in date and emergency drugs and oxygen were available for use in accordance with the Resuscitation UK Council guidelines.
- Controlled drugs regulated under the Misuse of Drugs Act 1971 (which, to prevent abuse, are strictly controlled) were stored at each location in a separate box with a control log book enclosed which was double signed and dated and when not in use, locked in the lockable cupboard, in accordance with the community dental service standard operating procedure for the management of controlled drugs.

Environment and equipment

- The community dental services were situated within modern, wheelchair accessible, multi-use buildings. The signage to find the dental service within the building was effective and there were reception desks for dental patients. Access to treatment areas was controlled by keypad locks on the doors. Adequate seating for adults and children in the waiting areas was provided.
- Staff described having ample equipment which was replaced when necessary. For instance, the vaccum autoclave at Arthur's Hill clinic was being replaced and a power socket for the autoclave printer was being installed and the intra-oral x-ray at Kenton was being repaired.
- All resuscitation trolleys in use at all locations were well stocked and checked daily. Each location had emergency equipment such as a defibrillator and a medicine box with emergency medicines and portable oxygen cylinders which both had logs which were checked and signed. We saw evidence that equipment was checked daily and maintained.
- Each location had a intra-oral and DPT (dental panoramic tomography) x-ray with local rules displayed to ensure safe operation, (although the DPT machine at Walker did not have its local rules displayed. This was drawn to the attention of the deputy radiation supervisor who informed us that this would be rectified). Each location had a radiology file containing local rules and results of tests undertaken to ensure the x-rays were operating safely to comply with regulations about ionising radiation. Test results seen showed that all x-ray equipment was safe to be used. The 2015 Annual Ionising Radiation (Medical Exposure) Regulations 2000 report states that no major problems with the performance of radiology equipment have been identified.

Quality of records

- Patient records were computerised and accessed by using a password. Any information not already in digital format was scanned onto the patient record, such as the referral letter. Any member of staff could access a patient record from any location using their password.
- We reviewed the records of 10 patients. All were legible and contained full details of medical histories, social histories, treatment plans, and consent. A quality assurance log for x-rays taken was maintained at each location and where seen x-rays taken were justified. NICE guidelines regarding dental recall ('Dental checks: intervals between oral health reviews NICE CG19') were seen to be followed and (in one record) safeguarding procedures involving the do not attend procedure were seen to have been used. In another record advice on oral healthcare was seen and there was a referral to a therapist. Another record involved a sedation and showed that vital signs were taken during the procedure and a supervisor in addition to the sedation trained nurse and clinician was present.

Cleanliness, infection control and hygiene

- All locations visited were visibly clean and tidy and used local decontamination processes to clean re-usable equipment which processes were observed to comply with HTM0105 ('national guidelines for decontamination and infection control in primary dental care'). Cleaning equipment, such as autoclaves and washer dis-infectors, had daily start up logs which were completed and signed.
- Staff observed were seen to be following hand hygiene good practice and carried dis-infectant gel dispensers with them or could access dis-infectant gel from dispensers on the wall or at one of the many sinks available. When providing treatment, staff were seen to wear personal protective equipment such as gloves, aprons and visors, and patients were supplied with goggles when receiving treatment. All PPE seen was disposed of safely in waste bins provided.
- Sharps bins were bracketed to the walls in accordance with recommendations, and single use items were

disposed of in clinical orange coloured bins. Sharps waste were removed by the trust's environmental team and other clinical waste was removed by third party waste removers.

- To ensure that standards of cleanliness, infection control and hygiene were maintained, once a month each location took its turn to complete a clinical assurance tool audit ('CAT') which looks at environmental cleanliness. For instance, at Kenton and Molineux the overall CAT score in September and December 2015 respectively, for environmental cleanliness, was 100%.
- Quarterly at each location there was an infection prevention society audit ('IPS'). For example, at Molineux and Arthur's Hill and Walker an IPS audit was undertaken on 13 August 2015 and 19 January 2016 respectively and overall the score achieved was 98% for Molineux and 100% for Arthur's Hill and Walker.

Mandatory training

- All staff attended mandatory training and received emails if they had not completed training when they should have. A system called 'Breeze' was used to log completion of mandatory training and the dental directorate manager monitored gaps in mandatory training and notified managers accordingly who then raised this with their staff.
- Staff spoken with did not report any issues with accessing mandatory training.
- Courses covered areas such as children and adult safeguarding (level 1), basic life support, and infection prevention.
- All managers spoken with said that they ensured staff were up to date with their mandatory training at the annual appraisal.
- The clinical lead for the service reported that compliance with mandatory training for community dental staff was in excess of 95% with some gaps due to staff being on leave. Training records of individual staff that were seen confirmed they were up to date with their mandatory training. However, mandatory training data supplied by the trust showed that, for medical and dental staff, the percentage who had complied with mandatory training varied, as follows: paediatric basic life support (100%); adult basic life support (78%); infection prevention control (89%); and children and adult safeguarding training to level 1 (both at 78%): all against a trust target of 95%.

Assessing and responding to patient risk

- At two locations we observed a team brief which took place before any treatment started. This dealt with: the clinic list and staffing; any known patient medical problems or behavioural needs; a check that the nurses had completed their jobs; a check that the resuscitation trollies had been checked; a run through that all equipment was working; a check on any oral health issues; any administrative matters; and any other business.
- To ensure that staff were equipped to respond to a medical emergency in an effective way, at each location regular emergency practice drills were performed.
- Patient records seen showed that full medical histories and risk assessments were completed so that staff were aware of how best to treat their patient.
- Staff spoken with said that patients were given as long as they needed in order to receive the best possible care. Appointments were arranged at a time and place to suit the patient. We were told that, if for any reason there was not enough staff in accordance with General Dental Council guidelines to enable safe treatment of the patient, the appointment would be cancelled and re-arranged.
- To prevent the wrong site administration of drugs, each location followed the pre-needle stamp process. This involved recording the details in the patient's notes, marking the correct side of administration on the patient's bib, and, before the injection was given, verbal confirmation between the team and immediately following administration, completion of a pre-needle stamp form which was signed.

Staffing levels and caseload

- Staffing levels were adequate to meet patient needs and safety. Staffing levels was discussed at directorate management meetings and at senior team meetings and was reviewed at the team brief. At the time of inspection, staffing levels consisted of a lead consultant in special care dentistry, five senior dental officers, seven clinicians, four senior dental nurses, 14 junior dental nurses, seven administration staff and three members of the oral health promotion team. Staff explained that the size of the dental staff ensured, (in accordance with the General Dental Council's

Good

Are services safe?

publication 'Standards for the Dental Team'), that when patients were receiving treatment there was always another appropriately trained member of staff present in addition to the clinician.

- Clinical and nurse staffing was managed in order to plan safe staffing to patient ratios, depending on the daily list for that clinic. Nurse establishment figures supplied by the trust for community dental services in the period July 2015 to October 2015 showed that, for band 4 and 5 nurses combined, there was adequate nursing staff, with the contracted rate exceeding the establishment rate for each month.
- At each location we were told most days the dental team was set but, if patient need or safety required it, there was always flexibility to move staff around between locations. The clinician's list (which consisted of special care patients and children) was always prioritised and staff were taken off the student outreach clinic list to assist as necessary and the student clinics were re-arranged.
- No vacancies existed for clinical roles but to provide cover for nurses taking maternity leave adverts had been placed for three dental nurse roles. Staff said there was little problem recruiting for the roles advertised.
- While inspecting the locations appointments ran on time and clinics started and ended when they were meant to.

Managing anticipated risks

- The service was clear about the patient referral criteria for treatment and this was clearly displayed. This helped the service to ensure that it could plan its services accordingly.
- We were told if staff were unexpectedly not present owing to travel complications or adverse weather or absent because of illness, so that it was not safe to proceed with a clinic, then the clinic would be cancelled and all appointments re-arranged.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We rated effective as good because:

- In order to deliver evidence based care focussed on the needs of their patient, we saw that a system was in place to share best practice across the community dental service. Each senior dental officer led on a speciality and each location maintained a 'best practice' file so that dental staff had access to relevant national guidelines such as on sedation, mental capacity, and guidelines issued by the 'British Society of Disability and Oral Health'.
- Patients and parents of patients spoken to reported that their pain was well managed. At each location there was information available about good nutrition to promote good oral healthcare.
- Systems were in place to capture patient activity and discuss patient outcomes and improve the patient experience including by carrying out local audits. Staff had undergone further training including on sedation, oral health, special care, radiology, fluoride application and teaching.
- The community dental service worked with the Newcastle Dental Hospital as part of a multi-disciplinary team and also with other medical specialities. The community dental service operated a mainly referral based service, and patients and parents of patients spoken to reported that they received clear information about what to do after treatment had finished.
- To support effective care of the patient, patient information was held electronically and all staff could access patient information from any location together with information about the trust's policies and procedures.
- Staff knew about the importance of consent and one of the senior dental officers led on the Mental Capacity Act and had been instrumental in developing a 'best interest meeting' agenda for use within the community dental service.

Evidence based care and treatment

- A system was in place to ensure the latest good practice guidance was in use by the staff at the community dental service. This involved the consultant who led the service sharing new guidance with senior dental officers at senior team meetings which would then be shared with staff at team briefs. For instance, we were told draft NICE guidelines for dental care at care homes was being considered.
- To embed the learning each location had a 'best practice' file available for use by staff. We reviewed these files and saw that they contained best practice guidance, such as, 'Standards for Conscious Sedation in the Provision of Dental Care 2015', issued by the dental faculties of the royal college of Surgeons and the Royal College of Anaesthetists and guidelines issued by the British Society of Disability and Oral Health.
- When a new practice was introduced into the community dental service its use would be audited, for instance, in relation to the use of student consent forms. For example, as a result of the student consent forms audit, a new procedure was introduced involving the use of a stamp and a formal signature and in addition a re-audit was planned in 2016 to monitor the changes made. Each senior dental officer was appointed to lead on a speciality such as safeguarding, sedation or consent and mental capacity. At clinician meetings one senior dental officer described how there was a system of 'peer review' because clinicians discussed cases of interest and shared best practice.
- Every six months the whole team would meet for half a day at a clinical governance meeting to receive information about any developments in best practice.

Pain relief

- We observed care given to patients and noted that the patient was asked about any pain and told to raise their hand to indicate if they were in any pain.
- Patients and parents of patients we spoke to all reported that their pain (or that of their child) was managed and that they were not in any pain while receiving treatment or afterwards.

Nutrition and hydration

Good

Are services effective?

- At each location visited we observed that there were posters on display about healthy eating in order to promote good oral healthcare.
- Each location had a stock of leaflets about promoting oral health.

Patient outcomes

- We saw that each location captured details of its activity by reference to: whether treatment was given by a student or clinician; whether there was an examination; whether the patient was a new patient; the treatment given; whether treatment was advised; whether treatment was urgent; whether there was relative or intravenous sedation; whether there was a home visit; and information about whether the patient attended.
- At the senior team meeting issues such as waiting times were discussed and plans were discussed, such as taking on more staff, if the problem persisted. We were told there was no waiting list for special care treatment whereas the waiting list for treatment by dental students which was 'free' could be long. This was discussed at a senior team meeting and it was decided to contact patients to ask whether they would be willing to travel to another location in order to receive 'free' treatment earlier.
- To look at patient outcomes a number of local audits were undertaken or planned. We were told an audit was planned to look at referrals into the service, domiciliary care, and re-call intervals and at the end of January an audit was planned to look at sedation need. We saw that a radiology audit had been completed in July 2015 and in December 2015 there was an audit of wrong site surgery guidelines in emergency medicine practice. Further, an audit of follow-up after urgent dental care and record keeping for urgent patients had both been completed. Minutes of meetings seen showed that the results of audits were discussed. For instance, the results of the radiology audit were to be used to help bid for a phosphor plate x-ray system.

Competent staff

- In order to maintain their competence, all staff spoken with reported that they had access to additional training over and above the mandatory training required by the trust.
- We saw that staff had been trained in sedation, oral health, special care, radiography, and fluoride application. In addition some staff had undertaken a teaching application so that they could train and teach dental staff. At one location we were told that staff attended a 'lunch and learn' session.
- All appraisals of staff were up to date or booked to take place. We were told by staff that at appraisal compliance with mandatory training was checked but also opportunities to undertake further training were explored. All staff spoken to welcomed their appraisal but emphasised that supervision took place throughout the year.
- By law, professionals who provide dental care must be registered with the General Dental Council (GDC) in order to work in the UK. All community dental staff supplied GDC registration information which showed their GDC registration was upto date. To maintain their registration dental professionals must meet the GDC's continuing professional development (CPD) requirements.
- Staff supported an outreach programme to train fourth and fifth year dental students which ran throughout the whole year. This involved supervising dental students who supplied treatment for free to patients who had specifically agreed to be treated by a student using a student consent form.

Multi-disciplinary working and co-ordinated care pathways

- In order to provide a better patient experience, whether by: reducing waiting times; providing treatment when other treatment was being provided; or ensuring treatment was provided for hard to reach patients, the community dental service worked with the Newcastle Dental Hospital and other medical specialities and agencies as part of a multi-disciplinary team.
- For instance, the consultant who led the service described how they worked at the Freeman Hospital screening patients in order to provide dental care to reduce the chance of infection while the patient was undergoing treatment at the cardiology, liver or renal units. A senior dental nurse described how she had worked with the urology unit to attend to the dental needs of a patient while they were having their other procedure.
- We were told the team worked with the Newcastle Dental Hospital on its oral surgery list by offering free

chairs within the community dental service to assess patients. Plans were being worked on to use the community dental service to provide oral surgery at a local clinic.
- Staff were able to describe how they had worked as part of a team in order to improve the patient journey. For instance, we were told about a patient who had high levels of anxiety. A multi-disciplinary team meeting with staff at the Newcastle Dental Hospital was called in order to plan a journey through the hospital which enabled the patient to be treated. Another example concerned a patient who would not attend for treatment. A multi-disciplinary team meeting with social services was called and arrangements put in place which led to the patient receiving the treatment they required.
- The oral health promotion team worked with schools with children who had special needs. It organised visits by the dental team to the schools to talk to the children and their parents about options for treatment and good oral healthcare.

Referral, transfer, discharge and transition

- The community dental service had a system in place to receive referrals from local general dental practitioners and the Newcastle Dental Hospital.
- When a referral was received it would be referred to a senior dental officer who would advise on the treatment required and an appointment would be sent to the patient. For patients who did not respond there was a system to chase them by phone and for regular non-attenders there was a weekly 'do not attend' report which was reviewed by dental staff for action to be taken.
- Patients and parents of patients spoken to confirmed that they found the appointment system worked well and that they knew what to do when they were discharged from the service.
- In one of the patient notes we reviewed there was evidence that staff supplied the patient, both verbally and in writing, with post operative instructions following the administration of a GA.

Access to information

- Information about patients was stored on computers which were accessed using a password. Staff could read about the patient such as their medical history, social history and treatment plan.
- Staff could access electronic copies of trust policies and procedures on the 'I' drive as well as in paper format within the files maintained at each location.
- After an appointment letter is sent to the patient a copy is sent to the referrer as well. In one patient record we saw that information was shared with a GP to ensure the issues raised were escalated. The patient was referred to the dental hospital for a GA. Another record showed how information had been effectively shared with a therapist who then referred the patient back once they had completed their treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The community dental service had appointed one of its senior dental officers to lead on consent and Mental Capacity Act ('MCA') issues. This staff member was part of a network that met every three months to discuss latest developments. Any learning was shared at senior team meetings and at team briefs.
- To support staff to observe best practice with regard to consent and MCA issues, each location visited maintained a MCA file which contained useful information about MCA issues and forms about consent and what to do if the patient could not consent. In order to promote best practice, at one location each surgery had a laminated MCA checklist with question prompts. At other locations, in clinical areas, there were flow charts about MCA issues.
- Information was displayed at each location about the advocacy service so that patients or their carers could access extra support to help them make the best decision about their care.
- Staff spoken to were aware of consent and MCA issues and evidence of consent was noted on some of the patient records seen. Staff described how they had used the advocacy service in order to make a best interest decision for a patient. All staff had received mandatory training about consent and the MCA.
- In the area of mental health, the senior dental officer who led on mental health issues had developed, with the trust's mental health team, a 'best interests' meeting agenda for use with patients who were unable to provide consent to treatment. This made sure that any carer, social worker, other health professional or interested person was invited to the meeting to input into the best interest decision.

Good

Are services effective?

- To check on the procedures being used, at the time of the inspection, an audit on MCA compliance was ongoing. This showed that 70 patient records had been reviewed to assess the community dental services compliance with the principles of MCA and consent. The results showed 100% compliance. The plan was to feedback to staff that documents could be clearer and to continue to obtain data and re-audit in six months time.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We rated caring as good because:

- All patients and parents of patients spoken with provided consistently positive feedback about the compassionate care and treatment they or their children had received. We also saw how staff interacted with a child awaiting treatment and spoke to them in a way that the child understood.
- Staff showed real understanding of their patients and those close to them. We saw an example of how a child patient was involved in their care.
- All staff spoken with showed real concern for patients emotional needs and could describe the steps taken to address these, such as providing longer appointments, or appointments before the surgery became noisy and busy.

Compassionate care

- During our inspection we saw that staff tried to understand children and took time to interact with them. We observed how staff interacted with a child patient who had special needs and spoke through an interpreter. The attitude of staff was caring and positive. Another child patient asked lots of questions (not necessarily about their treatment) and staff were observed to answer the questions patiently and using child appropriate language, displaying real warmth and compassion.
- We observed a child patient being given options for their treatment and the choice they made was respected. A further patient was observed being asked about their history and being told what the clinician was doing including agreeing how the patient could signal if they were in pain. The patient described the staff as "absolutely lovely."
- A different patient described how the staff took time to have a conversation. Another patient we observed was spoken to in a professional way, and advice was given about oral health and during treatment reassurance was given. The patient described the care and treatment as "brilliant" and said they particularly liked the time staff took to explain the care.
- A parent of a patient explained how treatment was explained and consent obtained before treatment started. We were told that they had recommended the service to a friend.
- Another patient said they were clear about their treatment and that "everything had been fine and ran very smoothly."
- The service took part in the 'Friends & Family' survey (FFT). In the period April 2015 to December 2015, for community dental services, (where there was no response in August, September and November), the majority of respondents said they were "extremely likely" to recommend the service, with no responder saying they were 'neither likely or unlikely'; 'unlikely'; 'extremely unlikely'; or 'don't know'.
- Also student dentists handed out patient satisfaction questionnaires. A patient satisfaction survey dated September 2015 for Arthur's Hill clinic scored 84% for patients strongly agreeing that: the care they received was good; the dentist used language they could understand; the environment was clean; they were greeted in a friendly manner; the dentist explained what they were going to do; and all questions were answered fully. For the same questions, in July 2015, the Molineux clinic scored 88% for patients strongly agreeing and the Walker clinic 91%.

Understanding and involvement of patients and those close to them

- We saw that staff took time to make sure patients understood their care and were involved in it. For instance, we observed a patient being given options for treatment and saw how staff showed real respect for the choice the patient made.
- A parent told us how staff discussed the treatment plan with them before treatment started and went through the consent process and discussed options so that their child knew what was coming and did so in a way that their child could understand.
- One staff member we spoke with described how they had developed a photo booklet so that patients with autism could familiarise themselves with the layout of the clinic before they came for treatment. We saw the photo booklet.

Good

Are services caring?

Emotional support

- Staff we spoke with told us that patients were given the time they needed for their care and we observed that a child with special needs was on their fourth appointment.
- A parent explained how they had taken their child to the service because they were anxious about treatment. The parent described how the service was not rushed and the appointment lasted for one and a half hours. On another occasion, they explained that while they were receiving treatment, staff offered to see their other child and took their time in order to understand what was going on.
- Staff spoken to were able to describe how they provided emotional support to anxious patients. For instance, one staff member described a patient who had high levels of anxiety about attending the clinic. The staff member explained how they met the patient outside of the clinic in non-work clothing and spoke to them about non-dental subjects in order to build a rapport and then slowly, over a matter of weeks and months, introduced dental words into the conversation. In order to deliver patient focussed treatment the clinician saw the patient before the clinic started when the environment would be quieter.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We rated responsive as good because:

- The consultant that led the service met with the commissioners every three months to discuss services and was looking to set up a managed clinical network of patients with special needs.
- We saw that the service had environments and facilities to ensure that it could provide dental care and treatment which was responsive to its patients. In one surgery patient confidentiality was enhanced by the use of screen guards so that only the person directly in front of the screen could see the information. At another location, where there was no screen guard, information on the screen could be seen on entering the room. Staff at the service adjusted the service to meet the needs of its patients. The service was demonstrably responsive to patients in vulnerable circumstances. For patients whose first language was not English staff described how they used the 'Big Word' interpreter service. A range of leaflets were available including about an eating diary or attending the Newcastle Dental Hospital. Care in the home was provided.
- In order to reach hard to reach patient groups, the oral health promotion team worked with the dental team to promote oral healthcare with local schools, the centre for the homeless and hospice based care agencies.
- We were told that waiting lists were reviewed at senior team meetings and steps taken to reduce waiting times.
- Complaints leaflets were available to the public at all locations together with details of how to access the independent advocacy service for those who needed more help in making a complaint. Easy read formats about the complaint process was available. Complaints were discussed at meetings and staff could describe how they had learnt from complaints and how complaints had shaped the service given.

Planning and delivering services which meet people's needs

- At all locations visited there was information displayed for patients about NHS charges and exemptions, together with information about the service and details about oral health promotion.
- The consultant lead for the community dental service explained that the service was planned based on the referrals received into the service. Commissioners were seen every three months and the consultant was hoping to set up a managed clinical network for patients with special care needs. Staff spoken with described how planning had to take place on a daily basis given the number of patients who do not attend and the special care being delivered by the service.
- Care in the home was provided and to plan and deliver care to hard to reach groups and generate referrals into the service, the dental team worked with the oral health promotion team to reach outside agencies, such as, local schools, mental health secure units and the centre for the homeless and hospice based agencies.

Equality and diversity

- The community dental service provided an environment that enabled wheelchair access right into the surgery itself. When in the surgery further support was provided by having hoists to enable patients with mobility issues to be safely moved from their wheelchair to the treatment chair.
- For bariatric patients there was a dedicated surgery with a bespoke treatment chair.
- At one location patient confidentiality was enhanced by the use of screen guards on the computers so that only the user of the computer could see the information on the screen. At another location, where the screen guard was not used, information on the screen could be seen on entering the room. In one location, patients who were anxious about dental treatment or who had special needs could benefit from a projector which displayed pleasant images on the ceiling of the surgery to help put them at their ease.
- One staff member was instrumental in creating the dental passport to support child patients who had

special needs. This was in the form of a booklet. On the front page there was a photo of the patient. On the following pages key information about the patient, such as trigger words to avoid, was displayed.

- The passport enabled the staff to understand the needs of the patient and deliver patient focussed care which went beyond just treating the physical symptoms. Also, to help promote clear communication with patients that had special needs staff had developed a communication board using 'makatons'.
- For patients whose first language was not English staff described how they used the 'Big Word' interepreter service.
- A wide range of leaflets were available in English about a range of subjects such as dentures, referral to the dental hospital, and keeping an eating diary. In accordance with the trust's policy, all material could be translated into another language if required.

Meeting the needs of people in vulnerable circumstances

- A staff member explained how they give their patients as long as they needed to ensure that they receive the treatment they need and how for a hard of hearing patient they secured a sign language interpreter.
- A different staff member explained how they saw a patient who had challenging communication issues over their lunch hour to enable them to give that patient the extra time they needed to complete the dental treatment required.
- We saw equipment staff had obtained to support patients with special needs access good oral healthcare, such as, aspirating toothbrushes and non-foaming toothpaste.

Access to the right care at the right time

- Across all clinics, to see clinical staff (as opposed to student dentists) a adult patient could expect to wait between 2 to 6 weeks depending on the length of the appointment required. We were told children are seen as a matter of priority and so the waiting lists related to treatment for adults. Patients are offered earlier slots at other clinics but we were told patients often decline preferring instead to wait to be seen at their local clinic. As at March 2016, waiting times in the community dental service were as follows: at Arthur's Hill clinic there was no waiting list for special care whereas students had a 1 month waiting list and there were 10 patients waiting for a sedation appointment. At Kenton there was no waiting list for clinical staff or dental students. At Molineux 14 patients had been waiting since October 2015 to see clinical staff. Lastly, at Walker, 25 patients had been waiting to see clinical staff since November 2015, with 8 patients awaiting a home visit since February 2016.
- The waiting lists were kept under review and discussed at senior team meetings and where necessary action planned to address any issues. For instance, to reduce the waiting time for sedations extra resource was arranged for the sedation list.
- To improve access to the right care at the right time staff told us how changes were made to the pre-assessment clinics for patients requiring a general anaesthetic ('GA'). Previously patients would be seen at a local community clinic for pre-assessment and then seen again for pre-assessment at the Newcastle Dental Hospital where GA's were given. To avoid seeing patients twice for pre-assessment the community dental team carried out the pre-assessment clinic at the Newcastle Dental Hospital so that patients only had one pre-assessment clinic. This also supported patients in becoming familiar with the dental hospital.
- An out of hours emergency service was managed from the Molineux clinic and provided emergency dental care when the clinics were not open. The service could be accessed by dialling 111.

Learning from complaints and concerns

- At all locations there were leaflets and posters on display about how to complain or make a compliment. To make complaining easier the service had developed a complaints leaflet for patients with special needs which used pictures. Also, for patients who needed help with complaining there were leaflets displayed about how to access the independent advocacy service.
- Patients or parents of patients we spoke with said they were aware about how to complain but had never had to.
- Since October 2015 the community dental service had not received any complaints. Staff reported that they rarely received complaints but if they did they would try and deal with them at a local level. For example, one patient with mental health issues complained about having to wait. Staff locally responded by ensuring that, in future, when booking the patient in, they were seen first, so avoiding any stress caused by having to wait.

Good

Are services responsive to people's needs?

- Complaints were discussed at team meetings and learning from complaints to improve and shape the service was evident. For instance, following a complaint changes were made to patient notes so that a symbol was inserted on the notes to support staff in not revealing the patient's address.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated well-led as good because:

- We were told a vision and strategy for the community dental service was in development and in the meantime the service had a directorate wide strategy which put quality patient care at its centre.
- A clear structure for governance existed and staff described a visible and approachable leader who encouraged new ideas. There was an open and honest culture within the community dental service.
- The public using the service was engaged using the 'Friends & Family ' survey and by providing friends and family feedback cards and boxes at reception.
- The community dental service was innovative because it had appointed as its lead a consultant in special care dentistry who could integrate the service with the Newcastle Dental Hospital. Also the staff were very proud of the outreach teaching programme they operated for fourth and fifth year dental students which, unlike other similar programmes which ran for a few weeks, ran throughout the year.

Service vision and strategy

- The community dental service's vision and strategy was in development but in the meantime there was a directorate wide strategy that put quality patient care at its centre. Staff spoken with had ideas about what should go into the strategy for the community dental service and spoke about putting patients first. For instance, staff described: wishing to set up a managed clinical care network for patients with special needs; expanding the dental staff; setting up a sedation service in the community for more complex patients (called 'tier 2'); setting up a anaesthetist clinic in the community to avoid patients having to have a GA; and working more with the Newcastle Dental Hospital.

Governance, risk management and quality measurement

- A framework for governance was in place which was monitored through a series of meetings. For instance, meetings took place at directorate level, clinical governance level, and at senior staff level. We saw minutes of these meetings. Issues discussed included: waiting lists; finance and activity; staffing; the risk register; patient complaints; and clinical governance. One of the recent actions taken included sourcing a new autoclave equipment for Arthur's Hill clinic. Each clinic held a daily team brief.
- In terms of measuring quality, while the service did not take part in any national audits, a number of local audits took place and we saw evidence of these. Audits were done on: follow-up dental care; domiciliary care; recall intervals; record keeping for urgent care patients; sedation referral; radiology; and student consent forms. For example, as a result of the student consent forms audit, a new procedure was introduced involving the use of a stamp and a formal signature and in addition a re-audit was planned in 2016 to monitor the changes made.
- At the time of the inspection there were no risks showing on the risk register for the community dental service although there was a generic risk for the whole directorate regarding waiting times. It was clear from the risk register that plans were in place to address the waiting list. In accordance with the 'Dental Directorate Management Structure Clinical Governance 2015 Handbook' the dental directorate (which includes community dental) reports to the Board through the medical director, who sits on the Board as an executive director. All staff spoken to said that they had access to the Board if required through their line management.

Leadership of this service

- The service was led by a consultant in special care dentistry who had been in post since August 2015. In order to lead the service and find out what staff thought the consultant lead for the service told us they visited clinics at least once a fortnight. Staff at the clinics confirmed this, telling us that their leader was very open, visible and approachable. For instance, one staff member told us how they were involved in discussing what to do about the equipment at one clinic and

Good

Are services well-led?

described how they felt really involved in plotting a way forward. All staff spoken with were very pleased to have a consultant in special care dentistry leading the community dental service.
- Each senior dental officer was given a role to lead on a particular area such as safeguarding, performance, sedation or mental capacity and consent.

Culture within this service

- We spoke with staff and asked them to describe the culture within the community dental service. One staff member said it was fantastic, with motivated and forward thinking staff. Other staff spoke about a culture that was very caring, with conscientious staff who took pride in their work with everyone putting patients first.
- Staff felt valued. For instance, we were told there was an issue with uniforms which were ordered centrally but it made more sense for them to be ordered locally. This was raised by staff as a concern and the process was changed to allow uniforms to be ordered locally.

Public engagement

- The community dental service took part in a range of initiatives to engage the public who use their services.
- The service took part in the 'Friends & Family' survey (FFT). In the period April 2015 to December 2015, for community dental services, (where there was no response in August, September and November), the majority of respondents said they were "extremely likely" to recommend the service, with no responder saying they were 'neither likely or unlikely'; 'unlikely'; 'extremely unlikely'; or 'don't know'. A 'your listening' poster was displayed at the locations we visited. At one location the feedback from patients said: "lovely friendly staff" and "staff very friendly and helpful".
- Also student dentists handed out patient satisfaction questionnaires. A patient satisfaction survey dated September 2015 for Arthur's Hill clinic scored 84% for patients strongly agreeing that: the care they received was good; the dentist used language they could understand; the environment was clean; they were greeted in a friendly manner; the dentist explained what they were going to do; and all questions were answered fully. For the same questions, in July 2015, the Molineux clinic scored 88% for patients strongly agreeing and the Walker clinic 91%.
- The oral health promotion team worked with the community dental team and health visitors to run 'hello and goodbye' events at local schools to promote oral healthcare amongst children joining and leaving school.
- One staff member described how they were working with the local dementia society by attending sessions and taking dental samples, such as, three-sided toothbrushes, and speaking to carers about promoting oral health. Also, they said they open up the clinic for seven year old children so they can climb on the chairs and touch the equipment to help them become familiar with a dental environment.

Staff engagement

- Staff we spoke with described feeling engaged. For instance, they took part in the staff survey, team briefs, team meetings, and received emails from the trust inviting them to take part in surveys if they wished to. In the 2015 staff survey results for the dental directorate, 79% of staff agreed/strongly agreed that they would recommend their organisation as a place to work and 95% of staff agreed/strongly agreed that their role made a difference to patients. An example of how staff engagement changed the service concerned lessons learned from a incident involving a repeat x-ray. This led to the creation of a new radiology request form to help support staff justify the necessity for an x-ray.

Innovation, improvement and sustainability

- Staff reported that the appointment of a consultant in special care dentistry to lead the service was an innovation. This was because it opened up the possibility of closer links with the Newcastle Dental Hospital and the realisation of a managed clinical network for patients with special needs.
- The community dental service took part in an outreach programme for fourth and fifth year dental students. Staff felt what was innovative about this programme was that it ran for the whole year whereas other programmes ran only for a few weeks. We were told this was the only programme of its type in the North East.
- The service was taking part in a pilot for a new NHS Dental Contract. One of the risks the service identified was that the proposed system did not permit changes to

Good

Are services well-led?

be entered on the system to reflect the complex patients it saw. This was fed back to the organisers of the pilot and changes were made to enable certain aspects of the system to be overridden to reflect patient need.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.