The Newcastle-upon-Tyne Hospitals NHS Foundation Trust

Dental Hospital

Quality Report

The Newcastle-upon-Tyne Hospitals NHS Foundation Trust
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Outstanding ☆
Surgery	**Outstanding** ☆

Summary of findings

Our judgements about each of the main services

Service	Rating		Why have we given this rating?
Surgery	Outstanding		Overall we rated the dental hospital as outstanding because:

- There were systems for identifying, investigating and learning from patient safety incidents. In 2015 there was one never event reported for the dental hospital. Never events are serious, wholly preventable patient safety incidents that should not occur if available preventative measures are implemented. The service had carried out a thorough investigation of the event and implemented actions to prevent recurrence and shared its learning with other dental hospitals and with national patient safety agencies.
- The environment was clean and infection prevention and control procedures well managed. Decontamination processes followed national guidance. Systems were in place for the safe storage and administration of medicines. Staff understood their responsibilities regarding safeguarding policies and procedures.
- Patients and relatives told us they had positive experiences of care within this service.We saw good examples of staff providing compassionate and effective care.
- Staffing levels were safe. There were processes for the regular review of staffing levels and changes made to meet the demands of the service.
- The dental hospital delivered care and treatment using relevant and current evidence-based guidance, standards, best practice and legislation. It proactively pursued opportunities to participate in benchmarking, peer review, accreditation and research. The service published several audit projects in peer-reviewed journals for wider sharing of findings. Improvements in practice were evident across dental services.

- Details of the teaching indicated that the curriculum covered all aspects of safe clinical practice for dentists in the UK. Training for student dentists was well-structured organised and received very positive student feedback The

Summary of findings

teaching for sedation was nationally recognised as working to the gold standard within the UK. There was effective team working and the use of innovative and pioneering approaches to care.

- The service was responsive to the needs of its patients. Access to care took account of patients' needs. Changes to clinics ensured waiting time targets were met and patients could access the right care at the right time.
- There was a strong, cohesive leadership team. Organisational, governance and risk management structures were effective. The senior management team were aware of the challenges of the service and the working culture was open, transparent and supportive. The dental hospital used innovative approaches to improve the standard and quality of patient care.

Dental Hospital

Detailed findings

Services we looked at
Surgery;

Detailed findings

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Background to Dental Hospital

The Dental Hospital in Newcastle primarily provides clinical experience for undergraduate dental students, student dental care professionals and qualified dentists undertaking further training. It also provides specialist services for referred patients in oral and maxillofacial surgery (OMFS), oral medicine, orthodontics, paediatric dentistry, and restorative dentistry (including treatment of the anxious patient and those with special care needs).

Newcastle's Dental Hospital (180 dental treatment chairs) is the major centre of specialist dental services for the northern region. It has three main areas: the Dental Hospital, the Community Dental Service and the North of Tyne Out of Hours Service. The North of Tyne Out of Hours Dental Emergency and Advisory Service provides advice and/or dental treatment to patients whose condition requires general dental services outside of normal opening hours.

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the inspection, we spoke with 20 patients and three relatives. We observed how patients were being cared for, talked with 30 members of dental staff, and reviewed care or treatment records of 14 patients who used the services.

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Care Quality Commission

Team Leader: Amanda Stanford, Care Quality Commission

The team included: CQC inspectors and a variety of specialists including: medical, surgical and obstetric consultants, a dentist, junior doctors, a paediatric doctor, senior managers, a paediatric nurse, nurses, midwives, a palliative care nurse specialist, a health visitor, physio and occupational therapists and experts by experience who had experience of using services.

How we carried out this inspection

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?

Prior to the announced inspection, we reviewed a range of information that we held and asked other

Detailed findings

organisations to share with us what they knew about the hospital. These included the clinical commissioning group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges, Overview and Scrutiny Committee and the local Healthwatch.

We held a listening event on 13 January 2016 in Newcastle to hear people's views about care and treatment received at the trust. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. We held focus groups and drop-in sessions with a range of staff in the hospital and in the community, including nurses and midwives, junior doctors, consultants, allied health professionals, including: physiotherapists; occupational therapists and administrative and support staff. We also spoke with staff individually as requested. We talked with patients and staff from all the ward areas, outpatient services and community sites. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

We carried out the announced inspection visit from 19 – 22 January 2016 and undertook an unannounced inspection on 5 February 2016.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Outstanding	Good	Good	Outstanding	Outstanding
Overall	Good	Outstanding	Good	Good	Outstanding	Outstanding

Surgery

Safe	Good
Effective	Outstanding ☆
Caring	Good
Responsive	Good
Well-led	Outstanding ☆
Overall	**Outstanding** ☆

Information about the service

The Dental Hospital in Newcastle primarily provides clinical experience for undergraduate dental students, student dental care professionals and qualified dentists undertaking further training. It also provides specialist services for referred patients in oral and maxillofacial surgery (OMFS), oral medicine, orthodontics, paediatric dentistry, and restorative dentistry (including treatment of the anxious patient and those with special care needs).

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Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the inspection, we spoke with 20 patients and three relatives. We observed how patients were being cared for, talked with 30 members of dental staff, and reviewed care or treatment records of 14 patients who used the services.

Summary of findings

- There were systems for identifying, investigating and learning from patient safety incidents. In 2015 there was one never event reported for the dental hospital. Never events are serious, wholly preventable patient safety incidents that should not occur if available preventative measures are implemented. The service had carried out a thorough investigation of the event and implemented actions to prevent recurrence and shared its learning with other dental hospitals and with national patient safety agencies.
- The environment was clean and infection prevention and control procedures well managed. Decontamination processes followed national guidance. Systems were in place for the safe storage and administration of medicines. Staff understood their responsibilities regarding safeguarding policies and procedures.
- Patients and relatives told us they had positive experiences of care within this service.We saw good examples of staff providing compassionate and effective care.
- Staffing levels were safe. There were processes for the regular review of staffing levels and changes made to meet the demands of the service.
- The dental hospital delivered care and treatment using relevant and current evidence-based guidance, standards, best practice and legislation. It proactively pursued opportunities to participate in

benchmarking, peer review, accreditation and research. The service published several audit projects in peer-reviewed journals for wider sharing of findings. Improvements in practice were evident across dental services.

- Details of the teaching indicated that the curriculum covered all aspects of safe clinical practice for dentists in the UK. Training for student dentists was well-structured organised and received very positive student feedback The teaching for sedation was nationally recognised as working to the gold standard within the UK. There was effective team working and the use of innovative and pioneering approaches to care.
- The service was responsive to the needs of its patients. Access to care took account of patients' needs. Changes to clinics ensured waiting time targets were met and patients could access the right care at the right time.
- There was a strong, cohesive leadership team. Organisational, governance and risk management structures were effective.The senior management team were aware of the challenges of the service and the working culture was open, transparent and supportive. The dental hospital used innovative approaches to improve the standard and quality of patient care.

Are surgery services safe?

We rated safe as good because:

- Staff spoken with understood their role in reporting incidents and near misses and could describe how they shared learning from incidents to improve patient safety. There was one never event reported in 2015. This was investigated and action taken to prevent reoccurrence. Patients received an apology and were told of any actions taken when something went wrong.
- There were policies and procedures to safeguard children and adults. Medicines were managed effectively. The maintenance and use of facilities and premises kept patients safe. Standards of cleanliness and hygiene were maintained and there were reliable systems to prevent and protect patients from infections.
- Staffing levels were safe with a good staff skill mix across the whole service.
- Staff identified and responded appropriately to changing risks to patients, including deteriorating health and well-being and medical emergencies. The service appropriately followed guidelines and checks for patients undergoing dental surgery.

Safety performance

- In 2015 the dental directorate had one never event relating to a wrong site local anaesthetic block. Never events are serious, wholly preventable patient safety incidents that should not occur if available preventative measures are implemented.
- The directorate had carried out a thorough investigation of the event and actions to prevent recurrence were implemented. The directorate redesigned the pre-needle time out policy and site marking using the 'STOP before you Block' posters and hand held boards. Other dental hospitals and the National Safety Standards were copying the process for Invasive Dental Procedures and had approached the trust to adopt the technique.
- Staff we spoke with were aware of the learning from the never event. We observed this process during a procedure.

Incident reporting, learning and improvement

- There were 138 incidents for the dental hospital between October 2014 and September 2015. Of these, the majority were categorised as low harm or insignificant and three were reported as moderate.
- Staff understood their responsibilities to raise concerns, to record safety incidents and near misses. Staff were able to clearly explain reporting processes and felt confident that follow-up action would be taken with appropriate feedback provided.
- Staff meeting minutes showed that incidents were discussed to facilitate shared learning. Learning from incidents involved additional training and reflection for staff and changes to practice.
- Staff were aware of the need to inform the patient following an incident and provide an apology. Incidents confirmed this process happened.
- The Duty of Candour regulations were embedded and the principles of being open and honest. The investigation report of the never event showed Duty of Candour was followed.

Safeguarding

- Records showed 100% of staff had received level 1 and 2 adult and children's safeguarding training and staff working in the children's dental department had completed level 3 training.
- Staff carried 'safeguarding is everybody's business' cards which contained contact numbers, and details of how to escalate concerns and the process to make referrals to safeguarding.
- Staff understood their responsibilities and discussed safeguarding policies and procedures confidently. They felt that safeguarding processes were embedded throughout the trust. Staff were aware of who to contact, where to seek advice and what initial actions to take.

Medicines

- Local anaesthetic prescriptions were written in patients notes and included details of the drug being administered, how it will be administered and the intended side of administration, including the drug batch number expiry date and dose.
- Emergency drugs were stored safely, sealed by pharmacy and dated. Records showed checks were made of medicines that required storage in fridges.
- Allergies were clearly documented in the prescribing document used.
- In the x-ray department contrasts for x-rays were stored securely. There was a sealed drug box containing an emergency dental box, which was in date.

Environment and equipment

- Records showed that resuscitation equipment and oxygen was checked daily and was easily accessible in all clinical areas.
- There were separate cubicles to ensure patient privacy and confidentiality during treatment. The emergency dental centre provided wide door access for wheelchairs.
- The sedation department was well equipped and suitably designed to allow access for treatment as well as consultations with patients away from the dental chair, which was of particular benefit to anxious patients.
- All medical devices and equipment maintenance was logged and recorded on a database. The database was live and updated on a daily basis. The Electronics and Medical Engineering Department were responsible for maintaining equipment.
- There was sufficient equipment to provide patient care such as hoists and bariatric equipment.
- Staff in the orthodontic department told us some of the equipment was 20 years old and in need of replacement. Plans for the refurbishment of the department identified these areas.
- The directorate had a named Radiation Protection Adviser and Radiation Protection Supervisors ensuring that the service complied with legal obligations under IRR 99 and IR(ME)R 2000 radiation regulations. The ionising regulations require periodic examination and testing of all radiation equipment, a radiological risk assessment, contingency plans, staff training and a quality assurance programme. The 2015 Annual Ionising Radiation (Medical Exposure) Regulations 2000 report showed that no major problems with the performance of radiology equipment had been identified.

Quality of records

- Records were completed to a good standard. These showed oral health assessments, medical and social history, smoking cessation, risk screening, dental pictorial charts and allergies. Where students had completed the record the dentist countersigned this.
- Treatment plans were signed by the patient to indicate that they had understood and accepted the procedure.

- Clinical records were kept securely so that confidential information was properly protected.
- Training records showed 100% of most staff groups in the directorate had received information governance training and 89% of medical and dental staff against a trust target of 95%.

Cleanliness, infection control and hygiene

- All clinical areas were visibly clean. Cleaning schedules were displayed on walls, and were dated and signed.
- We observed staff regularly washing their hands and wearing appropriate personal protective equipment, which was readily available. All staff followed the 'bare below the elbow' national hygiene guidance. An audit of hand hygiene technique showed 100% compliance in September 2015.
- An audit of infection prevention and control practices for September 2015 showed 100% compliance with the exception of the emergency dental clinic, which was 87% compliance. Data for environmental cleanliness was at 99%.
- Trust data for December 2015 showed dental staff knowledge of infection procedures was at 90%.
- The directorate had introduced a dental unit waterline cleaning procedure to ensure that appropriate water quality was maintained.
- We observed decontamination processes; these were carried out in line with best practice identified in Health Technical Memorandum (HTM) 01-05. However, we saw that wire brushes were used in washrooms. The HTM states that methods such as the use of 'wire brushes, which may give rise to surface abrasion, should be avoided'. The directorate told us they were getting disposable brushes which would meet infection control requirements.
- There were suitable arrangements for the handling, storage and disposal of clinical waste, including needles (sharps).
- We observed in oral surgery and in the sedation unit that aseptic infection control protocols were followed.

Mandatory training

- Staff attended mandatory training. A system was used to log completion of mandatory training, and the dental directorate monitored any gaps.
- Records showed 92% of staff had completed mandatory training. Resuscitation training was between 50-60% however, there was a plan to arrange training for remaining staff before the end of the year.
- Staff spoken with did not report any issues with accessing mandatory training.

Assessing and responding to patient risk

- The dental directorate followed the principles of the World Health Organisation (WHO) surgical safety checklist for local anaesthesia including the time out using the pre-needle time out stamp to help formalise and structure these processes at the chairside. The pre needle time-out was a mandatory component of any treatment in the directorate using local anaesthesia with or without conscious sedation.
- A WHO surgical safety checklist audit was performed in theatres between February and April 2015, where 17 theatre lists were analysed for OMFS. The results showed 100% of theatre lists had a team briefing prior to commencing the first patient, a sign-in, a time- out and a sign-out for all patients on the operating list, and 94% of OMFS theatre lists had a team debrief at the end of the list.
- We observed a general anaesthetic session. The patient's identity was checked, an explanation of treatment was given, records were checked by the anaesthetist, which included checking if the patient had fasted. The patient was monitored appropriately pre and post operatively.
- We also observed a conscious sedation. The patient was greeted, identified and consent to treatment confirmed. Intravenous sedation was given by using a single drug called midazolam. The patient was monitored closely using appropriate monitoring equipment during sedation. There was a recovery area where the patient was observed until they had made a full recovery from the procedure. The process was in line with the Standards for Conscious Sedation in the Provision of Dental Care Report of the Intercollegiate Advisory Committee for Sedation in Dentistry 2015.
- The directorate had developed an Oral Health Assessment tool for students, which was helping the next generation of dentists to be comprehensive in their examination of patients in restorative dentistry, and engaged them and the patients in risk assessments.

- The child dental emergency centre used patient pathways. Patients with swelling or trauma were seen immediately.
- There was a protocol for patients treated at the dental hospital who required acute hospital admission following a medical emergency, delayed recovery post GA or sedation or prolonged bleeding post surgery. Access to the on-call resident medical officer, anaesthetist and OMFS could be obtained for advice and/or transfer in an emergency.
- Dental co-ordinators asked the patient's general dental practitioner to assess those patients undergoing transplant in order to be sure no dental sepsis was present and there was no immediate need for dental treatment.

Staffing levels and caseload

- The dental hospital had adequate staffing to meet patient demand. There was a 4% vacancy rate across nursing and clinical support within the dental hospital. This equated to four whole time equivalent (WTE) members of staff. Recruitment plans were in place.
- The medical and dental staffing establishment at December 2015 was 104 WTE, which was 0.4% above funded levels.
- Dental staff were a mixture of consultants and newly qualified dentists, university employed clinicians and visiting practitioners to supervise students.
- Dental nursing teams were assigned to specific departments for example, oral surgery children's sedation and general anaesthesia. Senior dental nurses managed the teams. Staffing levels were flexible to meet the demand of the service. For example at peak times when students were attending the universities.
- Staff in the emergency dental service held senior meetings every Friday to discuss staffing levels. The department was fully staffed. The majority of treatment was provided by students with two to three junior qualified dentists present at all times and clinical supervisors. There was a suitable student to staff ratio.
- The OMFS emergency rota had been reconfigured to support greater consultant on-site availability for emergency care. This was to reduce patient waiting times for emergency surgery, better utilisation of the daytime emergency theatres and to ensure greater senior surgeon availability for emergency and trauma workloads.
- Medical locum use over a 12-month period was low at 3%.
- Turnover rates were approximately 6%. There were no problems with recruitment.
- We observed a comprehensive handover between students to clinical lead supervisor. The student provided the patients' medical history, any previous treatment, allergies and clinical risks.

Managing anticipated risks

- Staff had received resuscitation training and were aware of the escalation process during a major incident.
- Dental x-rays when prescribed were justified, reported on and quality assured each time. We saw dental records that confirmed the service was acting in accordance with national radiological guidelines and protected staff and patients from unnecessary exposure to radiation.
- There was an emergency preparedness and resilience policy and business continuity plan, which staff could access. The trust carried out emergency training exercises. The last one being in March 2015.

Are surgery services effective?

We rated effective as outstanding because:

- The dental hospital used relevant and current evidence-based guidance, standards, best practice and legislation to develop how services, care and treatment was delivered. It proactively pursued opportunities to participate in peer review and research. Several audit projects had been published in peer-reviewed journals for wider dissemination of findings.
- Quality and outcome information was used to inform improvements in the service.
- Patients' nutrition, hydration and pain was assessed and managed effectively.
- Staff received training and had the correct skills, knowledge and experience to do their jobs. Details of the teaching indicated that the curriculum covered all aspects of safe clinical practice for dentists in the UK. Training for student dentists was well-structured organised and received very positive student feedback. The teaching for sedation was nationally recognised as working to the gold standard within the UK.

- There was effective team working and the use of innovative and pioneering approaches to care and how this was delivered was actively encouraged.
- There was a holistic approach to planning patient referrals, discharge or transfer to other services, which was done at the earliest possible stage.

However:

- An audit of the quality of consent form completion for patients having inhalation sedation showed for the first cycle 30% of consent forms met the gold standard, the second cycle 40% and third cycle 60% of consent forms met the gold standard. The directorate was actively monitoring and reviewing how patients were involved in making decisions about their treatment and had taken action to improve consent processes.

Evidence based care and treatment

- Each department in the directorate managed its own audit initiatives. Certain audits were prioritised and assigned to individuals with responsibility to complete and monitor the audit cycle. For example National Institute for Health and Care Excellence (NICE) requirements and Faculty of General Dental Practice (UK) standards.
- The service was compliant with NICE guidance; Antibiotic Prophylaxis in Dental Services (CGD064) and Wisdom Teeth (TAG001).
- Staff at all levels were encouraged to take an active role in audit. All general professional trainees were expected to undertake at least one audit during their two-year programme.
- The clinical governance day and local departmental meetings were used to share audit outcomes. Some audits were carried out on a regional basis to allow cross service comparison and joint working. For example, orthodontics had biannual regional audit meetings, where protocols were developed and audits carried out in primary and secondary care.
- The x-ray department carried out quality control checks on images to ensure the service met expected standards.
- We saw evidence of a rolling programme of audits to monitor safety performance including safe site surgery compliance, infection control, radiographs, assessment of dental trauma, and consent.
- Changes and recommendations from audits included: development of a dental trauma pro-forma assessment sheet to be used on Dental Emergency Clinic (DEC) to improve and standardise history taking; local trauma guidelines to facilitate treatment planning and improve care; and expansion of the role of nurse telephone consultation.
- Details of relevant clinical research were evident and showed that staff were active in increasing their knowledge base to support safe and effective clinical practice. The directorate had developed a clinical research facility and achieved the award of academic clinical directorate status. This would increase the volume of clinical research undertaken.

Pain relief

- Dentists assessed patients appropriately for pain and other urgent symptoms.
- Patients we spoke with said their pain relief was well managed.
- There was a pain clinic held jointly with oral surgery and restorative dentistry with involvement of clinical psychology.

Nutrition and hydration

- Dentists and dental nurses gave healthy eating advice to their patients in line with the Department of Health's 'Delivering better oral health – the evidenced based toolkit on the prevention of dental disease'.
- There was fasting guidance in place to advise children and adults having dental procedures under general anaesthesia. Patients undergoing conscious sedation also received appropriate advice from dentists and dental nurses.

Patient outcomes

- The dental hospital proactively pursued opportunities to participate in peer review, and research. Several audit projects had been published in peer-reviewed journals for wider dissemination of findings. Results of all audits showed feedback into service development and improvement. For example, a review of patient experiences on discharge from oral day care surgery led to the development of a patient orientated discharge protocol.
- Dental staff used the Department of Health's 'Delivering Better Oral Health Toolkit 2013' when providing preventative advice to patients on how to maintain a

healthy mouth. This is an evidence based tool kit used for the prevention of the common dental diseases. Data showed the levels of tooth decay reported for Newcastle was 19% compared to the national average of 25%.
- Trust data for failed and removed dental implants showed between 2010 and 2015 the total number of implants placed in this period was 1,022 in 48 patients and the total failed implants was 18 in 14 patients. The success rate was 98% compared with a failure rate of 1%.

Competent staff

- Clinical and nursing staff were appropriately qualified and maintained their skills through regular training. This was demonstrated through their continued professional development (CPD) and revalidation.
- By law, professionals who provide dental care must be registered with the General Dental Council (GDC) in order to work in the UK. All dental staff supplied GDC registration information, which showed their GDC registration was up to date.
- Appraisal rates for dental staff groups were 100%. Staff we spoke with confirmed they had received an appraisal in the last 12 months.
- There was a close working partnership with Newcastle University Dental School and integration with Newcastle Community Dental Services. The directorate was the educational and training provider for dental care professionals, that is, Dental Nursing, Dental Technicians and Dental Therapists.
- Dental students told us they received excellent clinical supervision and a supportive learning and training environment. We observed students taking medical histories and undertaking procedures within their competencies and under clinical supervision. The teaching for sedation was nationally recognised as working to the gold standard within the UK.
- Dental nurses were qualified in areas such as sedation, orthodontics and managing patients with special needs.
- Dental nurses had completed NVQ level 3 decontamination training and some were NVQ assessors in this area.
- There was no specific training in communications with children but staff said they moved through different departments in the dental hospital and gained these skills by watching and listening to qualified staff.
- Students received training in orthodontics in the skills laboratory, in lectures and could observe in clinic. The department had appointed more registrars so were able to accept simpler orthodontic cases for training.

Multi-disciplinary working and coordinated care pathways

- We observed all necessary staff, including those in different teams and services, involved in assessing, planning and delivering patients' care and treatment.
- The dental multi-disciplinary team (MDT) worked with other departments such as oncology, cleft palate unit, orthodontists and the cranial facial clinic.
- A MDT (nursing, anaesthetic, surgical) project was introduced to reduce the length of stay, use of high dependency beds and analgesic requirements for orthognathic (straightening of the jaw) cases.
- An MDT for headache or orofacial (mouth, jaw, face) pain met each month with neurology, to decrease the number of visits for patients with comorbid problems and improve the effectiveness and efficiency of care.
- A consultant radiologist was available to support the dental hospital if an additional opinion was required in the analysis of x-rays.

Referral, transfer, discharge and transition

- The dental hospital accepted referrals from general dental practitioners, the community dental services, general medical practitioners and tertiary referrals from medical and dental specialists.
- The hospital had referral guidance, which identified patient acceptance criteria for treatment within the different dental specialisms.
- Patients attending the emergency dental centre with swelling, pain or trauma were seen immediately. If patients had pain out of hours, they were informed to call 111 or return the next day.
- Senior clinical staff according to the description of the case and the urgency with which patients needed to be seen triaged all referrals for assessment to the Dental Hospital. Joint waiting lists for each department were used.
- Patients after their specific course of treatment were discharged back to dental primary care for review and continuing care.

- A detailed departmental guideline document was available for sedation and this covered the appropriate referral, acceptance and treatment protocols to support safe clinical practice.

Access to information

- All staff had access through the trust intranet, to trust policy, best practice and evidence based guidance in relation to information governance as well as through mandatory training.
- Each clinic area had printed copies of relevant trust policies for ease of reference.
- All referring practitioners received a letter following assessment, once treatment was complete or if the patient failed to attend or complete treatment.

Consent, Mental Capacity Act and Deprivation of Liberty

- Records showed consent to treatment was taken in line with Department of Health guidance. This included the risks, benefits and alternative options of treatment. Verbal consent was recorded.
- We observed the consent process. The dentist clearly explained any potential complications, benefits and provided sufficient time for the patient to ask any questions. Written information about the procedure was also provided.
- An audit of the quality of consent form completion for patients having inhalation sedation showed for the first cycle 30% of consent forms met the gold standard, for the second cycle 40% and third cycle 60% of consent forms met the gold standard. Action taken to improve quality of consent forms was the implementation of a template setting out best practice, which was widely available in clinics and for new staff.
- Staff were aware of the 'Gillick' test to identify children aged under 16 who had the legal capacity to consent to medical examination and treatment.
- Where patients received treatment from students a consent for student treatment stamp was used. This was entered in the notes as a standardised approach to ensure patients were informed that the dental hospital was a teaching hospital and exposure to students was likely.
- Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care.
- Staff we spoke with understood the legal requirements of the Mental Capacity Act 2005 and had access to social workers and staff trained in working with vulnerable patients.

Are surgery services caring?

We rated caring good because:

- Patients and carers told us they had positive care experiences. Patients, families and carers felt well supported and staff displayed compassion, kindness and respect.
- Patients and their families were appropriately involved in and central to making decisions about their care and the support needed. Planned care was consistent with best practice as set down by national guidelines. Patients we spoke with understood their treatment plans and had received sufficient information about what treatment to expect.
- Staff supported the emotional wellbeing of patients, particularly where they were anxious or had complex needs.
- The dental hospital used different ways to obtain patient feedback to improve the quality of care.

Compassionate care

- Patients and carers we spoke with were all happy with the service, waiting times and the caring attitude of staff. We observed good interactions between patients and staff; patients were treated with dignity and respect.
- We observed that staff took their time to interact with children in a respectful and considerate manner. For example, one dental nurse showed an encouraging, sensitive and supportive attitude while speaking with a child.
- The directorate used a number of ways for patients to comment on any aspect of their care or inform staff of anything that would have made their visit to the department a more pleasant experience. For example, the trust used 'take 2 minutes – tell us what you think' boxes in public areas in the hospital. The trust real time patient feedback showed that between April and November 2015, 90% of patients would recommend the

dental service. Positive themes from the feedback included staff attitude, cleanliness and patient information. Negative themes from the feedback were overbooked clinics and car parking.

- The national Friends and Family test data for December 2015 showed from 15 responses, 73% of patients would recommend the service.
- A trust survey (April – May 2015) of 52 patients undergoing intravenous sedation showed 100% of patients either strongly agreed or agreed to statements such as a welcoming department, clear information given to patients and caring staff.
- Child friendly evaluation forms were used to capture feedback from children. For example, a child completed a smiling face that would recommend the hospital and written 'I was amazed at the great service'.

Understanding and involvement of patients and those close to them

- Patients and their families were appropriately involved in and central to making decisions about their care and the support needed. We found that planned care was consistent with best practice as set down by national guidelines. Patients we spoke with understood their treatment plans and they had received sufficient information about what treatment to expect.
- A survey of patients attending for sedation showed 68% of females strongly agreed (and 32% agreed) and 71% of males strongly agreed (and 29% agreed) that the instructions they were given for their treatment and visit were clear
- Dentists and nurses were available to ask questions about care and treatment at any time.

Emotional support

- Staff were clear on the importance of emotional support needed when delivering care. There were systems to provide a supportive environment for anxious patients including the use of conscious sedation.
- Patients with temporomandibular disorder (TMD) (a problem affecting the 'chewing' muscles and the joints between the lower jaw and the base of the skull) were provided with support from psychological therapies to encourage patient self-care in line with best practice.

Are surgery services responsive?

We rated responsive as good because:

- Services were planned and delivered in a way that met the needs of the local population. There was a joint approach to planning and delivery of care and treatment.
- The dental hospital was responsive to meet the needs of patients by providing flexible appointments and joint clinics. Patients with anxiety were treated in a supportive environment.
- Clinics were managed to ensure patients could access the right care at the right time. The dental hospital had provided extra clinics to reduce waiting times. Consultant two week cancer waiting time clinics had also been introduced to meet national targets.
- Complaints were handled effectively, and the outcome explained to the patient. There was learning and improvements made from complaints.

Planning and delivering services which meet people's needs

- The directorate worked closely with local commissioners of services, other providers, general dental practitioners, local dental networks and patients to coordinate and integrate pathways of care that met the needs of the local population.
- There was a joint approach to planning and delivery of care and treatment. For example, the directorate was liaising with external stakeholders regarding referral patterns and specialist care requirements.
- The directorate were aware of changes to speciality specific national pathways and they were responding to different approaches for the provision of both primary and secondary dental care.

Equality and diversity

- There were adjustments made to buildings to enable patients with various disabilities to access services. For example, one dental surgery was larger to enable wheelchair access.
- An interpreter service was available for patients whose first language was not English.
- Information was available in different languages and British Sign Language.

- The training records indicated that most staff had received regular update training in equality, diversity and human rights as part of the rolling programme of mandatory training.

Meeting the needs of people in vulnerable circumstances

- To save the patient time and avoid multiple appointments and improve joint working and learning across departments, joint clinics were held.
- The service had purchased a computerised local anaesthetic delivery service with the Haemophilia Centre for use by their patients to save expense and discomfort of haemophiliac patients.
- The dental hospital had appointed staff to combined roles to meet patient needs, for example, a Consultant in Special Care Dentistry leading the Community Dental Service, a joint Senior Dental Nurse role between Restorative Dentistry and cardiology support, and a combined laboratory manager roles in Restorative Dentistry and OMFS.
- To reduce patient anxiety, children, patients with learning disabilities and patients with significant anxiety were cared for and treated in an appropriate environment. There were extended and flexible appointment times.
- Information leaflets were available covering various conditions and dental procedures to enable patients and relatives to find further information. Instruction leaflets were available for patients following sedation, general anaesthetic and fasting.
- Patients received information and a help guide when they were discharged with dental implants. A copy was also sent to the primary care dentist for the review and maintenance of the dental implants.

Access to the right care at the right time

- Theatre utilisation fluctuated between 76% and 115%. Utilisation of more than 100% occurs when sessions overrun. The trust counted utilisation from the time the first patient enters the anaesthetic room to the time the last patient on the list leaves theatres.
- The directorate had introduced weekly consultant two week cancer waiting time clinics (CWT) on Friday mornings, to help achieve the CWT target for suspected head and neck cancer referrals.
- There was weekend working to reduce waiting lists, which were now completed. New patients were assessed within six weeks. Patients requiring treatment that was more urgent could be seen earlier.
- Dental services were open Monday to Friday 9am – 5pm. After 5pm and at weekends patients could contact the on-call oral and maxillofacial doctor.
- There were a team of four consultants who, working in pairs, triaged all primary care referrals received by the dental hospital to ensure rapid, equitable and appropriate assessment by the consultant and supporting team.
- Protocols were in place describing how patients were discharged from the service following general anaesthesia or sedation. Protocols we saw assured us that patients were discharged in an appropriate, safe and timely way.
- The directorate had established an endodontic (treatment of dental pulp) ‘troubleshooting’ clinic, where junior staff were working under direct supervision, receiving coaching and feedback, while increasing service capacity.
- The referral to treatment performance of the service was consistently above 90% for all non-admitted pathways between July 2015 and November 2015.
- The referral to treatment performance for admitted patients had fluctuated over the same period and had been inconsistent between the specialties of restorative dentistry and oral surgery with varying performance; however, as of 16 November 2015 all specialties were above 90%.
- Trust data for 2015/2016 based on 44 weeks showed that out of 87,061 attendances, 9,747 patients did not attend, 10,566 appointments were cancelled by the hospital (10%) and 18,899 were cancelled by the patient (19%).

Learning from complaints and concerns

- The dental hospital measured its quality performance through complaints. There were very few complaints about the service. For example, in 2014/15 100,000 patients were seen and 30 formal complaints were raised, (0.03%).
- Complaint information leaflets were available in all reception areas and contact details for the Patient Advice and Liaison service.

- Complaints were managed in line with the trust complaints policy and timescales. Patients were provided with an apology and clear explanation of what went wrong and any action taken.
- Patients we spoke with said they were aware about how to complain but had never had to.
- Complaints were discussed at team meetings and learning from complaints and concerns to improve the service was evident. For example, requests were made for information on emergency care and student capabilities. Patients attending the Dental Hospital now received improved information clarifying treatment provided by Dental Students and the availability of urgent care in between appointments.

Are surgery services well-led?

Outstanding ☆

We rated well-led as outstanding because:

- There was an effective and comprehensive process to identify, understand, monitor and address current and future risks.
- The local management team was visible and the culture was seen as open and transparent. Staff were aware of the organisation's vision and way forward. The staff we spoke with said they felt well supported and that they could raise any concerns with their line managers. Staff were proud of the organisation as a place to work. Staff were encouraged to develop new working practices and deliver improvement.
- A cohesive leadership team understood the challenges of providing good quality care. They had identified effective strategies and actions needed to address this. In particular, this was evidenced through the work undertaken to reduce waiting times and the action taken following the never event incident which were clearly embedded throughout the dental hospital.
- Staff were focussed on improving the quality of patient care. There was evidence of staff participating in local and national clinical research and audit to improve patient outcomes; a number of research projects had been published.
- Innovative approaches were used to gather feedback from patients and the public, and improvements made as a result.

Service vision and strategy

- The service could demonstrate a clear three-year strategy (2013/2016). This included a programme to ensure the service met the trust vision. The strategy included a programme to ensure that services and patient activities were organised in a way to improve operational efficiency and a better patient experience.
- The strategy set out the directorate's strengths, opportunities, weaknesses and threats and set out how the service would address these areas.
- Minutes from management team meetings showed the strategy was promoted and shared with staff.

Governance, risk management and quality measurement

- There was a clinical governance lead and deputy lead. Minor clinical governance queries were discussed and actioned locally in each department through discussion with, the senior nurse or technician, consultant, or, if appropriate, clinical speciality leads. More serious clinical governance queries or issues were raised with an appropriate member of the clinical governance committee with input from the service line manager.
- The clinical governance committee met monthly on the second Wednesday of each month.
- Staff attended clinical governance half day meetings to peer review and discuss cases.
- There was alignment between the recorded risks and what we were told by staff. Managers said the top three risks were waiting time management, dental water lines and single-handed consultants. Minutes showed these areas were discussed at the directorate clinical governance and departmental meetings each month. Areas of higher risk were escalated to the trust board for example, waiting time performance. We saw action had been taken to mitigate risks, for example, waiting times were now compliant with national targets.
- The systems for monitoring the quality care were always complete and up to date. This included the daily, weekly, quarterly and annual maintenance schedules and checks of equipment, medicines and materials, used for the provision of dental care.
- The dental hospital had proactively responded to a never event and following a thorough investigation had

implemented all actions to prevent reoccurrence. The actions were clearly embedded in the department and techniques were being shared with national safety agencies and other dental hospitals.

Leadership of this service

- A directorate manager, clinical director and the head of the dental school led the service. Each area had a clinical specialty lead and lead clinician.
- A cohesive leadership team who understood the challenges of providing good quality care managed the service and had identified effective strategies and actions needed to address this. In particular, this was evidenced through the work undertaken to reduce waiting times.
- We found the DEC was well led and inclusive. Staff were encouraged to develop new working practices and deliver improvement, for example, the use of pre packed treatment packs.
- Staff were clear about who their manager was and who members of the senior team were. They said managers were regularly visible in clinical areas.

Culture within this service

- Staff spoke positively about the services they offered and the creative ways they worked to ensure they met the needs of patients.
- The staff roles and responsibilities were clearly defined with a sufficient skill mix of staff across all staff grades.
- Managers operated an open door policy. Staff we spoke with said they were able to raise concerns. We observed that the directorate encouraged candour, openness and honesty.
- The 2014 Staff Survey results showed 95% of dental staff agreed/strongly agreed that their role made a difference to patients.
- Sickness rates were below 3%, which was better than the trust average.

Public engagement

- Each year, oral health promoters from the Dental Hospital visited schools as part of National Smile Month to talk to children about what harms their teeth and provide oral health advice and support. Four primary schools were invited to design a poster to help encourage other children to look after their teeth and mouth.
- The oral health promotion team also 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.
- The directorate used a number of ways for patients to comment on any aspect of the care that they had received or inform staff of anything that would have made their visit to the department a more pleasant experience. This included ‘Two minutes of your time tell us what you think’ patient booths situated in public areas of the hospital, the national Friends and Family test and real time patient feedback surveys and audits.

Staff engagement

- Staff told us they were involved in service planning, for example in oral surgery staff had been involved in the refurbishment and expansion of the unit.
- Staff explained how their systems and processes were always developing in line with latest research and guidance. We saw a number of areas of improvements following audits and innovative practice.
- There were monthly senior and line manager meetings and staff received regular one to one meetings.

Innovation, improvement and sustainability

- Staff were focussed on improving the quality of patient care. There was evidence of staff participating in local and national clinical research and audit to improve patient outcomes; a number of research projects had been published.
- There were financial challenges faced by the directorate however, this was managed through a dental financial dashboard. The dashboard was monitored at directorate meetings and action taken where required to ensure financial pressures did not affect patient care.
- Tablet computers were available in the postgraduate clinics to allow dentists to engage with the evidence base more effectively.
- The directorate had introduced computer based virtual surgery in the planning of jaw excision and reconstruction. The dental hospital was considered the leaders in this field with the experience in using this state-of-the-art package in the UK. It also demonstrated cross specialty multidisciplinary working between OMFS and Plastic Surgery.

Outstanding practice and areas for improvement

Outstanding practice

- The directorate had introduced computer based virtual surgery in the planning of jaw excision and reconstruction. The dental hospital was considered the leaders in this field with experience in using this state-of-the-art package in the UK. It also demonstrated cross specialty multidisciplinary working between Oral and Maxillofacial Surgery and Plastic Surgery.
- The dental multi-disciplinary team (MDT) worked with other departments such as oncology, cleft palate unit, orthodontists and cranial facial clinic. A MDT (nursing, anaesthetic, surgical) project was introduced to reduce the length of stay, use of high dependency beds and analgesic requirements for orthognathic (straightening of the jaw) cases. An MDT for headache or orofacial (mouth, jaw, face) pain met each month with neurology, to decrease the number of visits for patients with comorbid problems and improve the effectiveness and efficiency of care.
- The teaching for sedation wasnationally recognised as working to the gold standard within the UK.