Sheffield Teaching Hospitals NHS Foundation Trust

The Charles Clifford Dental Hospital

Quality Report

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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	Good
Surgery	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected the Charles Clifford Dental Hospital as part of the inspection of Sheffield Teaching Hospitals NHS Foundation Trust from 7 to 11 December 2015. We carried out this inspection as part of the Care Quality Commission (CQC) comprehensive inspection programme.

We rated Charles Clifford Dental Hospital as good. We rated safe, effective, caring and well-led as good. Responsive was rated as outstanding.

Our key findings were as follows:

- Infection control procedures were in place. The environment was clean and where maintenance issues had been identified these had been placed on the risk register.
- The acute dental service was effective and focused on patients and their oral health care.
- Patients and relatives told us they had positive experiences of care within this service.
- The use of clinical audit to monitor effectiveness and initiate improvements in practice was evident.
- The acute dental services at Charles Clifford Dental Hospital (CCDH) were well led.

We saw several areas of outstanding practice including:

- We saw examples of innovative care approaches for extremely anxious patients, and extended working hours to allow patients to attend evening clinics.

However, there were also areas of practice where the trust should make improvements. the trust should:

- Ensure that staff are sufficiently trained in mandatory training
- Take action in relation to compatibility of radiological imagery and the new electronic record system, to avoid the need for patients to walk between clinical areas mid-procedure which negatively effects their privacy and dignity whilst being treated.
- Review governance minutes so they are clearly labelled to identify which dental clinical stream the papers apply to, and have a robust system for taking appropriate action on areas of concern raised within these meetings.
- Review pathway documents so they are regularly reviewed, dated, version controlled and monitored.
- Review and establish robust procedures for gaining consent of patients for local anaesthetic extractions.

Professor Sir Mike Richards Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery	Good	Safety, effectiveness, caring and well-led were all rated as good. We rated responsive as outstanding. Staff protected patients from abuse and avoidable harm. Systems for identifying, investigating and learning from patient safety incidents were in place. Infection control procedures were in place. The environment was clean and where maintenance issues had been identified these had been placed on the risk register. The acute dental service was effective and focused on patients and their oral health care. We saw examples of innovative care approaches for extremely anxious patients, and extended working hours to allow patients to attend evening clinics. 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.We found staff to be hard working, caring and committed to the care and treatment they provided. Staff and students spoke with passion about their work and conveyed their dedication to what they did. The use of clinical audit to monitor effectiveness and initiate improvements in practice was evident. The acute dental services at Charles Clifford Dental Hospital (CCDH) were well led.Organisational, governance and risk management structures were in place.The senior management team were visible and the working culture appeared to be open, transparent and supportive. Both staff and students told us they felt well supported and able to raise any concerns. We were onsite at the Charles Clifford Dental Hospital for two days.We spoke with 48 members of staff, 15 patients, eight relatives of patients and reviewed 13 sets of patient notes.

The Charles Clifford Dental Hospital

Detailed findings

Services we looked at

CQC Registered Location The Charles Clifford Dental Hospital **CQC Location ID** RHQCC

Detailed findings

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Background to The Charles Clifford Dental Hospital

Sheffield Teaching Hospitals NHS Foundation Trust provided acute and community services for approximately 564,000 people in the Sheffield area. The Charles Clifford Dental Hospital (CCDH) is one of five of the main acute sites that belong to the Sheffield Teaching Hospitals NHS Foundation Trust.

CCDH is an NHS hospital built in 1953, providing specialist oral, dental and maxillofacial services, as well as routine dental care for training purposes at no cost for patients in Sheffield city centre and the surrounding areas. Consultations and treatments for routine dental care are undertaken by University of Sheffield (School of Clinical Dentistry) students under the supervision of experienced dentists, consultants, hygienists and therapists. In order to qualify for routine dental treatment at CCDH, patients must not already be undergoing a course of treatment with their local dentist. Emergency care is only provided for patients with acute oral dental problems.

Sedation was undertaken at CCDH; general anaesthesia was not provided at CCDH.

The CCDH is a dental teaching hospital linked to the University School of Clinical Dentistry in Sheffield and has an intake of 80 undergraduate dentists and 30 hygienists and therapists each year. It was currently expanding its post-graduate and research activities. There is a mixture of clinical and academic staff working at CCDH.

In October 2014 the community dental service merged with the CCDH and became a distinct clinical service area. The service was renamed the Charles Clifford Dental Services and has a single management and governance structure.

Our inspection team

Our inspection team was led by:

Chair: Professor Stephen Powis , Medical Director

Head of Hospital Inspections: Amanda Stanford, Head of Inspection

The team included CQC inspectors and a variety of specialists: CQC inspector, a CQC Specialist Community Dental Advisor, a Professor/Consultant of Dentistry and Dental Specialist Advisor, a Dental Nurse Specialist Advisor and an Expert by Experience.

How we carried out this inspection

We inspected this service in December 2015 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:

Detailed findings

- 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 8 to 11 December 2015. During the inspection we held a focus group with dental nurses who worked within the service, and met and spoke to a range of staff members including; nurses, doctors, therapists, administrative and clerical staff as well as support staff and porters. We met and talked with people who use services and their relatives and carers, who shared their views and experiences of their experience at the Charles Clifford Dental Hospital.

Our ratings for this hospital

Our ratings for this hospital are:

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

Surgery

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

Information about the service

Information about the service

Sheffield Teaching Hospitals NHS Foundation Trust provided acute and community services for approximately 564,000 people in the Sheffield area. The Charles Clifford Dental Hospital (CCDH) is one of five of the main acute sites that belong to the Sheffield Teaching Hospitals NHS Foundation Trust.

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Sedation was undertaken at CCDH; general anaesthesia was not provided at CCDH.

The CCDH is a dental teaching hospital linked to the University School of Clinical Dentistry in Sheffield and has an intake of 80 undergraduate dentists and 30 hygienists and therapists each year. It was currently expanding its post-graduate and research activities. There is a mixture of clinical and academic staff working at CCDH.

Summary of findings

Safety, effectiveness, caring and well-led were all rated as good. We rated responsive as outstanding.

- Staff protected patients from abuse and avoidable harm.Systems for identifying, investigating and learning from patient safety incidents were in place. Infection control procedures were in place. The environment was clean and wheremaintenance issues had been identified these had been placed on the risk register.
- The acute dental service was effective and focused on patients and their oral health care. We saw examples of innovative care approaches for extremely anxious patients, and extended working hours to allow patients to attend evening clinics.
- 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.We found staff to be hard working, caring and committed to the care and treatment they provided. Staff and students spoke with passion about their work and conveyed their dedication to what they did.
- The use of clinical audit to monitor effectiveness and initiate improvements in practice was evident.
- The acute dental services at Charles Clifford Dental Hospital (CCDH) were well led.Organisational, governance and risk management structures were in

Surgery

place.The senior management team were visible and the working culture appeared to be open, transparent and supportive. Both staff and students told us they felt well supported and able to raise any concerns.

We were onsite at the Charles Clifford Dental Hospital for two days.We spoke with 48 members of staff, 15 patients, eight relatives of patients and reviewed 13 sets of patient notes.

Are surgery services safe?

Good

Summary

We rated safe as good because;

- Nationally recognised guidelines were being followed to safeguard patients against harm, for example the World Health Organisation's (WHO) safer surgery checklist, compliance with the mandatory dental nurse training, HTM01-05, and radiological guidance. There was adherence to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and Ionising Radiation Regulations (IRR) 1999.
- A safe environment was maintained, with flexibility from staff to move resources to best meet patient's need.
- Infection prevention training, monitoring and audit were robust.
- There were robust systems in place to safely manage the provision of medicines to patients who required them.
- There was an open reporting culture. Staff were trained and encouraged to report clinical incidents including near misses on the electronic reporting system. This information was shared amongst staff groups to encourage learning and reflection.

However;

- Staff compliance with mandatory training for safeguarding of both children and young people and of vulnerable adults was below the trust threshold of 90%.
- Not all departments in CCDH provide paediatric care however the 34% compliance rate is based on all of CCDH staff not just those staff providing paediatric care. For the inspection in Dec 2015 the compliance rate was 62% for staff that require training (screen shot included).

Detailed findings

Safety performance

- There had been no never events reported at the Charles Clifford dental hospital. 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

- There were between 80-100 incidents reported at the hospital each month, which included near misses. It was reported in the July 2015 governance minutes that incident reporting had increased within orthodontics and the community. and Dental services had one occurrence of a moderate incident in the previous 12 months. There were no occurrences recorded of severe harm occurring from clinical incidents.
- A recently reported incident had resulted in a number of processes including provision of an apology and explanation as to the reasons for the incident which was provided to the patient (as required under the duty of candour), Staff had ensured patient welfare, and investigations had been instigated to review equipment to ensure it was fit for purpose and had relevant checks completed. A clinical review of the protection of soft tissues was initiated in order to inform protective procedural changes.

Incident reporting, learning and improvement

- The clinical leads and clinical senior nursing staff were fully trained in incident reporting, root cause analysis processes and risk categorisation.
- All dental staff were aware of these key individuals and were able to access them when required. The dental nurse trainer told us that all incidents were recorded despite size or severity, including near misses.
- All staff, including students, were trained how to use the electronic incident reporting system . We saw staff reporting incidents, including near-misses, on the electronic incident reporting system.
- The department compiled and distributed a governance report to all staff which was circulated via email on a monthly basis. This contains information about incidents, local risks, the current risk register and results of recent root cause analyses.
- A service manager we spoke with confirmed that an oral and dental quality dashboard was circulated via email to staff for awareness as well as a clinical governance papers which included details from the risk register.
- Changes in practice which had been implemented from lesson's learnt from incidents included the recent change in sharpes boxes to reduce the chances of staff obtaining needlestick injuries. This was supported by both occupational health and the needlestick policy which was available on the hospital intranet.
- We spoke to nursing staff who were able to explain that when something went wrong in hospital, the patient should be spoken to by members of staff who could explain what had gone wrong, what this meant for the patient and provide either an apology or regret for any harm caused. Staff did not necessarily refer to this process as 'duty of candour' but they were familiar with the open and transparent ethos this process enabled.

Safeguarding

- There was a safeguarding children's referral pathway available on the staff intranet and hard copies were kept by senior dental nurses in each of the clinic areas, and there were safeguarding link members of staff within the hospital as well as posters with internal contact telephone numbers for staff to refer to.If a child under the age of 18 did not attend an appointment, the trust's safeguarding children policy stated that this must be followed up by a health or social care practitioner immediately. We saw documented evidence of children's safeguarding concerns raised by staff within a set of patient notes we reviewed.
- Staff we spoke with were aware of safeguarding processes and said they received regular mandatory training. However, compliance with safeguarding mandatory training for children and young people and vulnerable adults was below the trust target of 90%, varying between 74 – 82%. Staff groups within the lowest compliance for this training, ranging from 0-43%, were within oral pathology and dental practice staff groups. Staff within oral pathology do not have direct contact with patients.
- We saw the paediatric dentistry department were completing an audit on the evaluation of Safeguarding Children Supervision Arrangements, which has been registered as audit activity for 2015/16.

Medicines

- Medicines were dispensed from CCDH via three routes; these were trust prescriptions, which could be dispensed at the pharmacy located onsite, dispensed direct to patients within clinic for those who had, for example,a disability and emergency prescription SF10

forms, which may be needed to supply an ambulance crew, although this was infrequently used. We saw appropriate proformas and prescription logs were in place.

- We saw that each department had large portable oxygen cylinders available in case of a medical emergency.These each had log sheets which were signed by staff and completed on a weekly basis.
- We saw that both standard prescription forms and controlled drug prescription forms were stored securely in lockable cabinets with designated key holders. The security of these cupboards, the stock levels and expiry dates were regularly checked by pharmacy. The majority of prescriptions were for internal dispensing at the Royal Hallamshire Hospital pharmacy.
- We saw that there had been no recorded significant incidents in relation to medication.
- If required, there were a small number of controlled drugs used for severe pain relief kept securely locked in a drug cupboard; these and other controlled drugs, such as midazolam were logged & dispensed according to hospital's Medicines Management policy. We were told that all medication given to patients was done in accordance with the trust's Prescribing of Medicines Code. We observed a nurse preparing for intravenous sedation, and saw that the expiry date and batch numbers of both midazolam and the reversal drug; flumazenil, were checked before only the specific quantity for the procedure was removed from the secure drug storage.
- Samples of toothpaste/mouthwash/gels were given as directed by dentist/doctor and specific written instructions about use were provided to each patient.

Environment and equipment

- CCDH was clean and tidy both in outpatient waiting areas and in the clinical areas where patient's received their treatment.
- We spoke to the infection control educator/trainer and saw evidence of an equipment care audit dated October 2015 which showed compliance with audit standards.
- We saw evidence of annual x-ray set services and calibration.
- Surgical items of dental equipment was provided in sanitised sealed, labelled and dated trays, the same as theatre equipment. Decontamination and sterilisation of dental equipment was outsourced and the procedure was completed offsite with the santitised equipment returned to CCDH. Annual audits of waste and segregation were completed.
- The hospital has two secure adult portable resuscitation trolleys. . Each was organised in the same manner with dedicated draws for drugs and miscellaneous items. Each trolley was tamper resistant with plastic tags. We were told by a member of the senior dental nurse team that the trust's pharmacy department managed the drugs inventory for the drugs trolleys and they kept a database of expiry dates, maintaining the stock of the trolleys with in-date provisions. The senior dental nurses checked the integrity of secure devices if the trolley was located within their management area.
- Some staff raised concerns about the poor quality of some areas of trust estate which they felt impacted on both patient experience and service efficiency. For example, some areas of floor had been temporarily fixed with the use of duct tape. This had been added to the risk register and was due to be discussed at the next estates meeting.
- A capital bid had recently been submitted to secure funds to start some of the repair and refurbishment work.
- It was acknowledged that some of the hospital's estate required modernising in terms of accessibility and updating cosmetic appearance. We understand that a capitol bid has been submitted ahead of this appearing on the risk register, in order to improve the physical surroundings
- A new electronic records system had recently been introduced at the trust. The new system did not allow for the x-ray image to be projected on the screen at the time of a patient's treatment. This compatibility and image access issue was discussed within the oral Surgery, oral medicine, oral pathology, orthodontics (4 O's meeting) which we attended on 9 December 2015. This issue had been escalated to the central project team who had trialled reconfigurations and had worked with administrative staff to test system changes.
- Radiology services were provided within the CCDH under the Medical Images and Medical Physics (MIMP) methodology. Radiology services were consultant led and included CT scanning, ultrasound, standard extra and intra-oral radiology.

- Radiology within the DPU conformed to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 and Ionising Radiations Regulations (IRR 1999) regulations.
- The DPU held a radiation protection file which contained; local rules, radiology risk assessments, critical examination packs, maintenance logs for staff to refer to, to ensure adherence with protocols.

Quality of records

- CCDH used a mixture of paper based and electronic systems for the purposes of record keeping. The majority were paper based.There was an ongoing pilot for the roll out of a new electronic data management system.
- All test results, with the exception of oral pathology, were available on the electronic requesting system (Integrated Clinical Environment (ICE). The process to put oral pathology results on ICE had started and was due for completion in early 2016.
- Dental radiographs were stored within picture archiving and communication system (PACS) and could be accessed within both CCDH and within the Dental Practice Unit (DPU).
- During our inspection we reviewed 13 randomly selected sets of patient notes. We found the majority of patient notes had been signed by the clinician and consent was obtained as part of the treatment plan process, however 50% of notes were not fully legible.
- Review of paper patient notes within the DPU demonstrated that medical and dental staff justified the use of x-ray, which was reported on and quality assured.
- A record keeping audit had been undertaken within orthodontics. The audit reviewed a random selection of 30 sets of patient records over an eight week period in May to June 2015. This identified areas of non-complianc including the presence of patient identification sticker on each page of notes (40%), and whether radiographs were reported on with clinical findings in the patient notes (30%). There was a six point action plan and a re-audit had been scheduled for February 2016.
- Electronic patient records have recently been trialled within CCDH. Community teams used practice management software which contained appointment booking systems for each dentist. Patient details kept on the community system were not electronically transferrable to the hospital's system if a patient moved between community and hospital treatment. This relied on paper copies being provided for CCDH for continuity of patient care.The DPU used another electronic system. If patients were transferred between DPU to CCDH then a paper copy of the records was produced. DPU had full access to CCDH's radiology and investigative test ordering systems.

Cleanliness, infection control and hygiene

- There were robust cleaning and maintenance processes in place to manage the dentistry sterilisation machine (autoclave) within the dental practice unit, and the lead infection control educator/trainer provided training for students on how to use and safely maintain this equipment. Daily audits were conducted by dental nurses to ensure cycle validation, and we saw evidence of both autoclaves receiving engineer servicing in March and November 2015.
- We observed good infection prevention and control practices across the hospital. Hand washing facilities and alcohol hand gel were available throughout the clinic areas.
- We observed staff following hand hygiene and 'bare below the elbow' guidance. We saw full personal protective equipment (PPE) being used by staff treating patients, such as aprons, gloves and face masks, as recommended in national guidance. We observed appropriate disposal of PPE.
- The hospital employed an engineer to inspect dental equipment and review the service history to ensure compliance with HTM01-05 standards. This formed an element of the equipment care audit, which we saw had last been completed in October 2015.
- We reviewed the last six months CCDH hand hygiene audit data for each of the dental departments. Results covered the period June to November 2015 and demonstrated that all areas had consistently achieved 100% compliance with trust standards, with the exception of restorative dentistry which ranged in compliance between 90-100%.
- The November 2015 infection control hospital wide audit was rated 'green', demonstrating good compliance with audit criterion.
- There were recent risk assessments completed for sharps injuries and infection control dated October 2015.
- We observed within oral surgery and sedation units that aseptic infection control protocols were adhered to.

- Audits were undertaken on the disposal of waste and segregation, and these were repeated on a yearly basis.
- We spoke with the lead infection control educator. They showed us recent risk assessments for infection control and sharps risk assessment for the use of the single use system for needles.
- There were hand-washing champions within each department who were responsible for auditing and monitoring hand washing within their department on a monthly basis. We saw evidence of additional infection prevention audits which were completed on a six monthly basis by the infection prevention educator who was the nominated lead for infection prevention within CCDH, and also the infection control link nurse for the trust's infection prevention team.

Mandatory training

- CCDH mandatory training results were 78% compliance which is lower than the trust target of 90%. The lowest compliance was for paediatric resuscitation (basic life support) at 34%.
- Staff mandatory training records were managed by the Trust's online Personal Achievement Learning Management System (PALMS) system. Paper copies were kept in individual staff records and the clinical educator could request training records from the senior dental nurses for any of their students/staff.
- The infection prevention educator provided face-to-face training for nursing staff and trainee dental nurses for mandatory dental training. This included HTM01-05 (Department of Health national decontamination guidelines for dentistry) and basic life support (BLS). They had access to the electronic mandatory training system and proactively worked with staff to identify training needs, often providing scenario based learning for students and staff.
- We saw a certification template for clinical staff to have completed a half day of mandatory training which accounted for verifiable continued professional development (CPD).

Assessing and responding to patient risk

- The trust policy for the management of the deteriorating patient was used to ensure nursing staff and allied health professionals (AHPs) could recognise patient deterioration.
- We found that dental staff always recorded patient safety and safeguarding alerts. For example, medical histories were always taken by dentists and updated when patients attended for dental treatment. These medical histories included any allergies and reactions to medication such as antibiotics.
- We were told by the governance lead nurse that there was an anti-coagulant system to check patient's International Normalisation Ratio (INRs) prior to surgery, and there were five trained members of staff who could check this.
- Staff used the Sheffield Hospital Early Warning System (SHEWS) and Situation, Background, Assessment and Recommendation (SBAR) tool to escalate deteriorating patients appropriately to medical staff for timely assessment and treatment. This policy stated that management of the deteriorating patient was included within resuscitation training as part of job specific training.
- Patients having minor oral surgery or exodontia were given instructions on how to contact the hospital if concerns arose. Between 9am-5pm they were asked to phone the clinic and out of hours to phone the Royal Hallamshire Hospital and ask to speak to the dentist on-call or I1 ward. Oral and Maxillofacial service (OMFS) was available 24 hours a day to manage any patient concern arising out of hours.
- We saw that best practice guidance was followed for patients requiring sedation at the CCDH in the form of intercollegiate guidelines published in April 2015.
- We were told by senior dental nurses that they often worked with clinicians to provide students with six to eight medical emergency scenarios to work through as a team and share learning. We were told that this was generally an effective teaching method to use with students in a 'learning on the job' situation which was then documented and shared with the team.
- All departments within CCDH had their own version of the World Health Organisation's (WHO) safer surgery checklist to aid mitigation of incidents during clinical procedures.
- We observed the trust's local version of the World Health Organisation's (WHO) safer surgery checklist was used during a local anaesthetic tooth extraction, which followed best practice guidance for this procedure.

Staffing levels and caseload

- Staffing within each clinic area was provided flexibly, organised prospectively and according to clinical need

and demand. We reviewed the staffing levels for the first week of December 2015 and saw that nurse staffing for the week was between 83-94% planned capacity. Dentists had staffing as planned for the week.
- CCDH did not use any clinical agency, bank or locum staff. They utilised a system to encourage staff to take leave within the summer holidays and over the Christmas period, so that cover can be retained over winter pressure periods.

Managing anticipated risks

- We spoke with senior nursing staff within restorative dentistry who told us about the plans the department had in place for managing medical emergencies, including delegated roles and processes for reporting medical emergencies. Dental clinical leads and clinical senior nursing staff were all trained in risk registration, and details of risks were circulated on a monthly basis as part of the governance report to all staff.

Major incident awareness and training

- The dental departments carried out simulated medical emergency training with either a dental nurse educator or resuscitation officer.
- They also held half or full day simulated medical emergency training for students demonstrating a number of potential emergency situations to help students experience as close to real-life situations as possible with peer support.

Are surgery services effective?

Good

Summary

We rated effective as good because;

- There was an extensive clinical audit programme which was used to monitor clinical practice against trust and or best practice standards, make changes to practice and continue to monitor effectiveness for patient treatments and experiences.
- The Charles Clifford Dental Hospital (CCDH) had engaged with the National Audit programme and had action planned against the report which had been received from the national project team. This demonstrated that for the majority of indicators CCDH was matching or exceeding national percentages.
- All educational trainees were supported with an educational and clinical supervisor.
- CCDH fully utilised patient centred care in relation to pain relief. Clinicians made individual assessments for individual patient requirements.
- A holistic approach to individual patient's requirements was modelled within CCDH, and anxious patients had the option of utilising cognitive behavioural therapy (CBT), acupuncture, hypnosis, inhalation, or intravenous or oral sedation to assist with their dental treatments.
- The lead infection control educator had recently been awarded a nationally recognised qualification in dental decontamination for infection control nurses.

However;

- We had concerns that evidence based pathway documents were not regularly reviewed, dated, version controlled and monitored.
- Staff did not receive Mental Capacity Assessment (MCA) or Deprivision of Liberty (DOLs) training, although there was an MCA facilitator available for support and advice.

Detailed findings

Evidence based care and treatment

- CCDH has a national and international reputation for both its teaching, and research. Ninety-two percent of research undertaken at CCDH was graded as 'world leading' or 'internationally excellent'.
- We were assured that CCDH was providing patient care in line with national best practice guidance.
- Paediatric dentistry had 15 local audits with three which were linked to national guidance.
- Orthodontic dentistry had 13 local audits with two that were associated with either clinical risks or clinical concerns registered for completion this year. A couple of these were service reviews such as 'the causes and incidence of unscheduled appointments in the orthodontic department at CCDH', and there was one based on whether patients attending met the NHS England criteria for commissioning.

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- Restorative dentistry had 12 local audits and the thirteenth was linked to a national clinical audit patient outcome programme (NCAPOP) namely; Accuracy of dental radiograph prescribing & reporting and use of SALUD for reporting at CCDH.
- Oral Maxillofacial Surgery department was involved with an head and neck surgical oncology (DAHNO) NCAPOP audit.
- The four 'O's' had an audit registered on this year's audit plan based on the NICE Smoking Cessation standards.
- We saw evidence of a number of patient pathway documents linked to national best practice, for example, the paediatric dentistry department care pathway for children with anaemia, a care pathway for spinal injury patients, and a care pathway for dental anxiety and phobia which provided an innovative approach to treatment options for patients.
- We observed a patient having an extraction via a local anaesthetic, and noted that the surgical safety checklist was used and details of the procedure were placed on the whiteboard.

Pain relief

- The patient notes we reviewed demonstrated that pain assessments and treatment plans were in place. The pain assessments were not formally recorded using a scale, but instead narrative was written in the notes from the assessing clinician. Dentists reviewed each patient individually and prescribed pain relief, as appropriate.
- Analgesia was given to the patient by the dentist or doctor who wrote a prescription within the patient's hospital notes and oversaw the administration. This was recorded within the patient's hospital notes, as per the trust's 'Prescribing of Medicines Code.'
- The hospital did not use patient group directions (PGDs) for providing pain relief to patients; prescriptions for treatment were signed individually by dentists, if procedures are conducted by hygienists or therapists.
- Staff told us that assessment of pain is left to the discretion of the clinician as different methods are appropriate in each patient case.

Nutrition and hydration

- We saw that 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'.

Patient outcomes

- The clinical audit process within CCDH was supported by the Clinical Audit and Effectiveness team.
- CCDH took part in the National Clinical Audit Patient Outcome Programme (NCAPOP) for Head and Neck Cancer (DAHNO) in 2013/14; the report was published in July 2014. Findings from this national audit report demonstrated that generally Sheffield Teaching Hospitals were meeting and often exceeding national percentage returns. The report highlighted that the trust performed below the standard for having a clinical nurse specialist (CNS) present at the breaking of bad news (10% against a national average of 48%), but markedly exceeded national averages for discussing patients at multi-disciplinary team (MDT) meetings (100% against a national figure of 96%), and by providing pre-treatment chest imaging by diagnosing trust (91% against a national figure of 68%). An action plan had been devised for the responsible service manager to make changes to the patient and CNS interactions and we could see that the majority of these actions had been completed. This national audit was not currently running due to a project team change, but the trust continued to collect data for this current year.
- X-ray audits were completed quarterly and we saw evidence of January 2015 and April 2015 audit reports. We also saw a copy of the annual x-ray audit report.
- We saw two audit reports completed this year in July and November 2015 entitled; Surgery and Critical Care Paediatric Dentistry and Exodontia which looked at record keeping, the results were compared, and matched, the previous audit cycle's results. There were recommendations made but no action plan or mention of re-audit, and the results were to be shared within the September paediatric dentistry audit meeting. The second audit was 'standards and legibility of orthodontic case notes'. The main finding from this audit was 30% of the 30 reviewed had radiological

interpretations recorded in the notes. There was one action following this audit with a plan to re-audit. Audit outcomes were to be shared at the next Orthodontic audit meeting.

Competent staff

- Dentists and dental nurses had a professional obligation to maintain their skills and knowledge and this was demonstrated through their continued professional development (CPD) and revalidation. The senior dental nurses responsible for each clinic area kept a log of training requirements to ensure compliance was maintained.
- We saw data confirming that 84% of appraisals were completed for April to September 2015, (target 85%).
- All clinical trainees were provided with an educational and clinical supervisor.
- Clinical training for dentists not in training posts was provided via bi-monthly case conferences to discuss complicated cases. There were also ad-hoc meetings within clinics; details of these were recorded on the peer review data collection form and used for appraisal purposes. We saw two anonymised examples of these sets of papers.
- The service used a separate provider for central decontamination of dental instruments with the exception of the DPU which had an autoclave onsite. On this site students were trained how to manually operate an autoclave to equip them for using one post training.
- All consultant staff was compliant with the required training to provide clinical supervision.
- We spoke with a senior dental nurse in Restorative Dentistry who was able to fully explain the process for managing a medical emergency and we were shown a proforma for reporting a medical emergency.
- There were staff training folders which contained individual's training matrix. This was reviewed as part of staff's appraisal process and included continuous revalidation for the General Dental Council (GDC). Within these folders training needs were identified and plans put in place to address individual's training requirements.
- Appraisals had been completed for all of the dental nurses and there was a rolling programme system which notified when staff's appraisals were due for completion. Senior dental nurse appraisals were completed by higher dental management members of staff.
- We spoke with the infection control Educator who had attended training courses as part of her continued professional development (CPD).We saw that she had recently taken part in an infection control training programme which resulted in her obtaining a nationally recognised qualification in dental decontamination for infection control nurses.
- The infection control educator told us that the dental hospital currently has a dedicated maintenance engineer to resolve maintenance issues and support the delivery of high level patient care. To ensure continuity, an apprentice engineer was currently being trained.
- We saw evidence of occupational health support being provided to assist staff effective working.
- Any agency or bank administrative or clerical staff that are employed have the same induction checklist as substantive staff to ensure they have the same understanding of policies and procedures.
- Staff were encouraged to develop and a number of the dental nurses we spoke to had undertaken additional training to enable them to deliver nurse-led clinics, which consequently freed up qualified dental hours in order to treat more patients, some dental nurses had also expressed their wishes to attend community clinics in order to establish better integration with community teams.

Multi-disciplinary working and coordinated care pathways

- The dental practice unit worked with the local dental unit to provide an evening consultant led oral surgery clinic one night a week.
- Dental staff worked with oncology colleagues to collect data for the Head and Neck Cancer (DAHNO) National Audit.
- The paediatric dentistry department care pathway for children with anaemia, dated 2011 mapped potential patient journeys and demonstrated multi-disciplinary working by requesting clinicians and anaesthetists specialist input where required. The care pathway for spinal injury patients, provided prompts for treating patients on wards where appropriate, and prompts for discussing cases in discharge areas, for ongoing care of spinal patient's oral and dental care in the community,

another example was that of the pathway for dental anxiety and phobia which potentially required input from specialist skilled practitioners for provision of cognitive behavioural therapy (CBT), hypnosis and acupuncture. This pathway has been cited in the national dental literature as an example of exemplary practice.

Referral, transfer, discharge and transition

- Patients were able to refer themselves in to the dental hospital, if they are not already undergoing a course of treatment with a local dentist, and were prepared to potentially wait longer than normal for treatment completion due to this being completed by students under close supervision.
- Patients were triaged over the telephone by administrative staff, who had access to the clinic bookings for emergency dental care. The same dental criteria which was used nationally by all dental practices or dental access centres was used by the hospital; if patients presented with bleeding, trauma, swelling, abscess, infection or pain that could not be controlled by over the counter analgesia, an appointment would be provided If clinics were full, administration staff would call through to the department and ask if the patient could be seen at the end of the clinic list.

Access to information

- There was a range of electronic systems used for requesting tests, radiology reports and managing appointments in the dental hospital, the dental practice unit and also for those patients treated in the community. Where systems were not accessible between sites the methodology was to ensure that paper copy notes were provided to ensure continuity of patient care.
- All staff had access via 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 and the senior dental nurses ensured that these were kept up to date.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Consent to treatment was reviewed in the notes as part of the teaching plan for undergraduate students working in clinics.
- We saw mandatory training matrixes and noted that there was no mental capacity act or deprivation of liberties (DOLs) training for staff to complete, but the hospital had a Mental Capacity Act (MCA) facilitator who staff could access for advice and support. We did speak with a dentist who told us that they had requested an interpreter to ease with understanding of a special care patient and the dentist in order that the patient had the ability to fully understand treatment options and make an informed decision.
- A referral form was completed online. If the patient is deemed acceptable for student's to treat, a consent form is completed by the patient to give authorisation for treatment by a student.
- We saw that there was patient information leaflets available about being treated by dental students, and there was a consent proforma that patients were required to sign before starting a course of treatment with a student.
- The majority of patient records we reviewed were well documented, and in a couple of instances we saw that appropriate consent had been undertaken and documented prior to the patient receiving clinical intervention.
- Consent for local anaesthetics was under review as this had not previously been collected. This is not mandatory or required by the general dental council (GDC). This was discussed in the November four O's meeting, and the chair of the meeting had drafted paperwork to be trialled. The consent element would be on the bottom of the patient's treatment plan, and the patient would be asked to sign this to verify that they understood the risks involved in having an extraction. There was still the option to complete a full consent form process if clinicians felt this was necessary, but the chair added that feedback would be sought from the trial process to help develop these new consent forms.
- We were supplied with the names of senior staff across the trust that were the nominated leads for learning disability, vulnerable adults, children and young people, safeguarding children.

Surgery

Are surgery services caring?

Good

Summary

We rated caring as good because;

- Staff were welcoming, warm and engaging with patients.
- Information was made accessible to patients about the treatment options available, in the form of discussions with clinicians and patient information leaflets available.
- Where possible, staff ensured patients in pain were seen as soon as possible.
- Staff were sensitive to the needs of vulnerable patients, making reasonable adjustments to ensure that effective two-way communication was achievable to allow patients to be fully empowered to make decisions about their treatment options.
- We observed, and patients confirmed that; care was provided in a calm, safe and caring environment.
- Follow up calls were provided to patients following clinical interventions, to ensure that patients were recovering well.
- Patients said that staff enabled them to feel 'at ease' whilst receiving treatment within the hospital.
- Staff provided person-centred and specific care to individual patients.
- NHS Choices rated the Charles Clifford Dental Hospital 4.5/5 having reviewed 60 patient feedback responses for the month of December 2015.
- Direct feedback from patients was very positive about the level of care individuals had received in the service.

However;

- We were concerned that patient's dignity may be compromised whilst the x-ray equipment on level 2 and 3 were not working with the introduction of the Electronic record system, as patients were required to access radiological services elsewhere in the hospital when part way through treatment.

Detailed findings

Compassionate care

- Almost all the 15 patients we spoke with were positive about the service.
- We saw that there were patient information leaflets available in clinic waiting areas covering a variety of clinical conditions, as well as how to make a complaint.
- The CCDH received four-and-a-half stars out of five across a review from 60 patients in December 2015 on the NHS Choices website.
- We felt that each of the clinic areas had calm atmospheres and this was confirmed via our discussions with 15 patients during our visit to the CCDH.Staff and patients told us how staff would telephone patient's at home after significant procedures to make sure that the patient was comfortable with their recovery.
- The hospital's x-ray provision on levels two and three were unusable due to the introduction of new x-ray software on the computers. Staff told us that this meant that occasionally patients were required to move from one level to another whilst in vulnerable or exposed situations such as whilst fitted with a mouth guard, which forced their mouth open.

Understanding and involvement of patients and those close to them

- Parents attending clinics with their children spoke of the high levels of personalised care their children had received at the hospital.
- We spoke to a doctor who explained how she worked with patients with Multiple Sclerosis (MS). The doctor was very calm in her interactions with the patient and explained that sometimes she used an interpreter to assist her to ensure that she is clear that the patient understands the treatment options available to them, so that they could make a fully informed choice about the next stages of treatment.
- Patients we spoke with told us that staff would not do anything until you told them you were ready.

Emotional support

- We observed positive interactions between staff and patients where staff knew the patient well and had built up a good rapport with them.

Surgery

- Patients we spoke with said that staff made them feel at ease as they felt they could ask any question they may have had about their treatment. Vulnerable patients we spoke with, spoke of staff's ability to make them feel just like 'anyone else'.
- The majority of comments received were positive about patient's experiences, one patient said; "I feel safe when I am here because there is never any trouble". Senior nursing staff told us that dentists often telephoned patients once they were home to make sure that they were recovering well from treatment, and they felt that this helped patients to feel more inclined to attend future appointments.
- Patients were advised before they arrived in clinics that CCDH was a teaching hospital and as such patients received treatment in open clinic environments, however there was also the provision of there being four side rooms for private consultations at the patient's request.

Are surgery services responsive?

Outstanding ☆

Summary

We rated responsive as outstanding because;

- The service worked with a local dental unit to provide an out of hours oral surgery consultant led clinic for patients who were unable to be released from work within core hours, enabling them to attend one evening each week.
- The trust had made reasonable adjustments to enable patients to access services, such as disabled parking spaces close to the hospital, access ramps into the building and lift access to levels one to three within the hospital.
- We heard that patients were prioritised according to need, for example the service aimed to see patients with trauma or facial swelling on the same day.
- Staff aimed to resolve any patient complaints within a face-to-face personal relationship with the complainant rather than responding in a less personal manner.
- The trust used communication aids such as interpretation services, signing services and induction loops for patients with hearing difficulties to ensure that two way communication was possible.

However;

- Recovery arrangements for patients following post-intravenous sedation was very crowded and the curtains did not provide privacy.

Detailed findings

Planning and delivering services which meet people's needs

- Nursing staff in the dental practice unit told us that the hospital worked with the local dental unit to provide an evening consultant led clinic between the hours of 5pm to 8pm for oral surgery one evening each week, which may assist with accessing services outside of core working hours.
- Staff and patients had access to 78 dental patient information leaflets on the trust's website which could be sorted alphabetically or by condition for ease of access. Each had a compilation and review date at the bottom of the sheet and of the random selection that we viewed; all of these were currently in date. Two of the generic dental patient leaflets were available in easy read format.
- In the Dental Practice Unit (DPU), Nurse-led pre-assessment clinics were held for patients requiring sedation prior to dental surgery, which was considered exemplary practice by our Specialist Advisors.

Equality and diversity

- Adjustments had been made to buildings to enable patients with various disabilities to access services; however there was limited space available to manoeuvre wheelchairs in some of the corridor areas of the hospital.
- Signing services or induction loops were available to patients hard of hearing within the hospital.
- Disabled parking was available outside the hospital.
- The trust's website contained a hyperlink to translation software so that information contained on the website could be accessed by a number of languages.

Meeting the needs of people in vulnerable circumstances

Surgery

- We were told by nursing staff in the Restorative Dental department that patients suffering trauma or facial swelling are seen on the same day as they are referred. If they could not be seen that day or have an NHS dentist the hospital signposted them to the urgent, but not life threatening NHS '111' service. This process was confirmed by the reception staff as being accurate.
- We observed staff being conscious of patient's anxieties and provided reassurance and were clear in explaining about the treatment. Staff allowed patients time to respond if they were not happy or in pain.
- We observed a pre-treatment team brief where all staff discussed the roles required for the session, instrument requirements, patient's medical history as well as any specific patient needs.
- Recovery arrangements for patients following post-intravenous sedation was inadequate with patients located in ambulatory chairs just outside of the main operating theatre. Physical space was minimal and the fabric curtains surrounding each chair was so close to the patient that you could often see limb outlines while they rested. This is recognised by staff and has been fully risk assessed and documented.

Access to the right care at the right time

- In December 2015, 94.7% of patients were being seen within the government target of 18 weeks from referral, at CCDH.
- The hospital booked three days in advance for urgent cases where patients are in pain, offering a minimum of 20 appointments a day.
- We spoke with the patient access team who said that patients telephoning the hospital for treatment are initially triaged by the team, according to if they have a National Health Service (NHS) dentist and their symptoms.
- The hospital did not have a contract to deliver urgent care. Any 'urgent' appointments offered to patients were prioritised based on clinical need. Some patients were invited to have continuing care (restorative dentistry) with undergraduates if they wished.
- To ensure continuity and minimise distress for patients transitioning from paediatric to adult clinics, the same nurse in paediatrics would attend the adult clinic with the patient.

Learning from complaints and concerns

- At each governance meeting both formal and informal complaints were discussed in order to share learning and allow reflection to take place. We saw examples of governance meeting minutes which confirmed that these discussions took place.
- We also attended the 4 O's meeting and saw and heard staff discussion complaints and resolutions. There had been a low number of complaints (nine) received by CCDH within the last year. Two were in relation to availability of appointments and seven were in relation to clinical treatment.
- We saw that there was 'how to make a complaint' leaflets in patient waiting areas.
- We spoke with a Clinical Service Manager who led on patient complaints, who told us that where possible complaints were dealt with at a local level. This meant that where possible if a patient wished to make a complaint or raise a concern this was managed face-to-face with a member of staff which may include the PatientServices Team (PST).. If this level of interaction was successful then a written record was kept of this liaison with the patient, if not then this would then progress to the formal complaints route.
- The formal trust policy complaints process involved an initial telephone call to the patient to gain clarity, and then involved up to 25 working days to investigate the patient's concerns.
- A recent example of a complaint and a local resolution was provided to us. This showed the trust had responded and an outcome had been agreed. Lessons learnt were included the importance of confirming and managing a deteriorating patient.
- The complaint's process is supported by the trust Governors who visit wards and departments to 'spot check' progress against action plans.

Are surgery services well-led?

Good

Summary

We rated well-led as good because;

- The staff we spoke with said that they felt very well supported and able to raise a concern with their line managers.

Surgery

- The culture felt open and transparent and attendees at the dental nurses' focus group spoke of management being approachable, supportive and sincere.
- The Charles Clifford Dental Hospital staff actively sought feedback from patients, relatives and the public by using feedback cards, and a patient and public involvement strategy to improve services to meet the needs of the local population.
- We saw several examples of innovation across the domains of caring, effective and responsive which was indicative of a well-led service.
- Staff were passionate about the services and levels of care that they provided for their patients.

However;

- We had concerns about the follow-up of actions raised in governance meetings, and how these were escalated or monitored for completion by staff, an example being concerns about receiving community appraisals from staff in July 2015 but no mention of it subsequently.
- There was an issue with insufficient space within the paediatric waiting area. This issue had been risk assessed and was on the risk register. This issue was discussed within the governance meetings.
- We were not assured that there were robust systems in place to ensure that all staff were monitored on their compliance with mandatory training, or that this was reported on at a senior level.

Detailed findings

Service vision and strategy

- We observed staff who were passionate and proud about working within the service, providing good quality care for patients, which demonstrated the trust's values of 'PROUD'; Patients-first, Respectful, Ownership, Unity, and Deliver.
- The oral and dental directorate had developed a performance dashboard to monitor specific metrics and this data together with the directorate business plan was presented to the trust executive group (TEG) at least twice a year, in order to provide assurance that staff continued to work to the directorate strategy.

Governance, risk management and quality measurement

- The Charles Clifford Dental Services directorate is composed of the community service and the CCDH and sits within the Head and Neck Care Group.
- There were robust governance systems in place. Senior members of staff managed the risk register which was electronically sent as part of the governance papers which included meeting minutes to all members of staff on a monthly basis. We also saw a programme of planned audit activity which was red, amber, green (RAG) rated according to project progression.
- We saw robust systems and processes in place regarding radiology clinical governance and compliance with IRMER 2000 and IRR 1999 radiology guidelines.
- We had some concerns that issues were being raised in governance minutes, but there appeared to be no evidence of any action taken to resolve the issue. An example of this was that concerns were raised in the meeting about receiving community appraisals from staff in July 2015, then there was no mention of it in the next set of minutes in October 2015.
- Staff we spoke with told us that mandatory training figures were good, but this was not reflected in training records. Children's resuscitation training compliance for those that required it was low at 62% against a trust target of 90% completion.

Leadership of this service

- We visited oral surgery and sedation units and observed team meetings. Within the team meetings staff discussed individual roles for the session, any patient complexities, as well as instruments required within the session. We saw Consultants discussing radiology images and procedures with nursing staff colleagues, before the patient was brought into the treatment area.
- We attended the December 2015 oral surgery, oral medicine, oral pathology and oral radiology (4'O's)operational meeting which discussed; management issues, staffing issues, patient care matters, community dentistry, executive reporting, clinical governance and audit. The meeting was well attended, the agenda was adhered to and discussion points minuted.

Culture within this service

- Many staff we spoke with talked of the working environment feeling like a family one – many staff

members had been working at the hospital some considerable number of years and many had started their training at the hospital and progressed through their careers staying, or returning to the hospital.
- We held a dental nurses focus group as part of the inspection and within this we heard how nursing teams used handover books to communicate key messages for the following day's staff briefing to allow for smooth continuation of patient care.
- Across the combined clinical streams, CCDH has a vacancy rate of 1.5%. Staff we spoke to at the time of inspection had been at the trust a significant number of years. Some staff had progressed from initial dental training through a career path in the hospital. The general consensus was that there was a strong team spirit and sense of belonging to provide a high standard of patient care. Data provided showed that 30 medical or dental staff had left the trust in the last year demonstrating a 28.6% turnover rate, which was partially to do with students.

Public engagement

- The service undertook regular patient satisfaction surveys.
- The trust used 'tell us what you think' cards on reception desks to capture patient and relative feedback.The trust hosted a number of events to raise patient and staff awareness of the importance of clinical research, to demonstrate what research meant and how to get involved. CCDH is involved with the National Institute for Health Research (NIHR).

Staff engagement

- Staff engagement was evident in the use of medical emergency 'real-life' training scenarios which involved all levels of staff, from undergraduate students through to Consultant, the collective worked as a whole team to share learning outcomes. We felt that this was a really positive and interactive method of experiencing and teaching.
- Governance meeting minutes dated 21st May 2015 discussed lunchtime staff engagement sessions which were being held to discuss friends and family survey results.
- In November 2015 the trust initiated the 'listening into action' methodology which began with a staff engagement event entitled; the big conversation. Themes arising from this included: feeling valued, being efficient, being able to do jobs to the best of individual's ability, making things better for patients, being better connected, being PROUD, and getting the staffing right. This work is being progressed by a team and progress is planned to be fed back to staff in the summer of 2016.
- November 2015 four 'O's' meeting discussed that for CCDH the staff survey return was at a 40% reduction on last year's figures. CCDH was rated in the top ten in the Guardian university guide, with a student satisfaction rate of 97%.

Innovation, improvement and sustainability

- Staff were supported by the local management of the service to access and attend training. Supported access ensured that dental staff had the appropriate skills and training to make effective clinical decisions and treat patients in a prompt and timely manner.

Outstanding practice and areas for improvement

Outstanding practice

- An holistic approach to individual patient's requirements was modelled within CCDH, and anxious patients had the option of utilising cognitive behavioural therapy (CBT), acupuncture, hypnosis, inhalation, or intravenous or oral sedation to assist with their dental treatments.
- Staff were sensitive to the needs of vulnerable patients, making reasonable adjustments to ensure that effective two-way communication was achievable to allow patients to be fully empowered to make decisions about their treatment options.
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Areas for improvement

Action the hospital SHOULD take to improve

The trust SHOULD;

- Ensure that staff are sufficiently trained in mandatory training
- Take action in relation to compatibility of radiological imagery and the new electronic record system, to avoid the need for patients to walk between clinical areas mid-procedure which negatively effects their privacy and dignity whilst being treated.
- Review governance minutes so they are clearly labelled to identify which dental clinical stream the papers apply to, and have a robust system for taking appropriate action on areas of concern raised within these meetings.
- Review pathway documents so they are regularly reviewed, dated, version controlled and monitored.
- Review and establish robust procedures for gaining consent of patients for local anaesthetic extractions.