Mr. Mohammed Azfar Hyder

Ferryhill Dental Health Centre

Inspection Report

Old Sorting Office
2 Durham Road
Ferryhill
DL17 8LG
Tel: 01740 651124
Website: http://www.burgesshyder.com

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Overall summary

This inspection was an announced focused inspection carried out in January 2018 to confirm that the provider had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection between 3 and 6 April 2017. The April 2017 comprehensive inspection was carried out in partnership with Her Majesty's Inspectorate of Prisons (HMIP) under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions in accordance with our published methodology. The joint inspection report can be found at:

https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-haverigg/

This report covers our findings in relation to those aspects detailed in the Requirement Notice issued to Ferryhill Dental Health Centre.

We do not currently rate services provided in prisons.Our key findings were as follows:

• The provider had made improvement to the governance arrangements and monitoring of services at HMP Haverigg.

The action taken by the provider ensured that patients were receiving safe and effective treatment.

However, there is an area where the provider SHOULD make further improvements:

• The provider should keep comprehensive records of clinical and managerial supervision carried out for dental clinicians.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?
We did not inspect the safe key question in full at this inspection. We inspected only those aspects identified as requiring improvement in the joint inspection report published by Her Majesty's Inspectorate of Prisons on 16 August 2017. We found that the areas of concern identified in April 2017had been addressed.

The provider ensured that all staff including those not directly employed were appropriately checked and that services provided were safe.

Are services effective?
We did not inspect the effective key question in full at this inspection. We inspected only those aspects identified as requiring improvement in the joint inspection report published by Her Majesty's Inspectorate of Prisons on 16 August 2017. We found that the areas of concern identified in April 2017 had been addressed.

The provider had improved supervision arrangements and ensured that services were effective.

Are services caring?
We did not inspect this key question during this inspection.

Are services responsive to people's needs?
We did not inspect this key question during this inspection.

Are services well-led?
We did not inspect the well-led key question in full at this inspection. We inspected only those aspects identified as requiring improvement in the joint inspection report published by Her Majesty's Inspectorate of Prisons on 16 August 2017. We found that the areas of concern identified in April 2017 had been addressed.

The provider now ensured that appropriate support mechanisms were in place for staff providing dental services at HMP Haverigg and that the quality of the service was appropriately monitored.

Ferryhill Dental Health Centre

Detailed findings

Background to this inspection

HMP Haverigg is a category C male training prison situated in West Cumbria. At the time of the last joint comprehensive inspection in April 2017, HMP Haverigg was holding around 300 adult male prisoners, less than half its previous population following a decision by the then National Offender Management Service (now known as Her Majesty's Prison and Probation Service (HMPPS) to close two accommodation units because the safety of prisoners living there could not be assured. The population remained around 300 during this focused inspection.

Health services at HMP Haverigg are commissioned by NHS England. The contract for the provision of dental healthcare services at HMP Haverigg is held by Ferryhill Dental Health Centre.

CQC inspected this location with HMIP between the 3 and 6 April 2017. We found evidence that fundamental standards were not being met and one Requirement Notice was issued in relation to Regulation 17, Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We subsequently asked Ferryhill Dental Health Centre to make improvements regarding this breach. We checked these areas as part of this focused inspection and found that the provider had addressed the issues identified that fell within their control and remit.

This inspection was carried out by two CQC Health and Justice inspectors.

We undertook a desk based review of evidence submitted by Ferryhill Dental Health Centre to determine whether the provider had made the planned improvements to meet legal requirements. This inspection focused only on the areas of regulatory breach identified during our joint comprehensive inspection in April 2017. We reviewed:

- An updated version of the provider's action plan
- The recruitment policy
- Vetting checks for non-directly employed staff
- Complaints data and quality reviews
- Minutes of joint governance meetings
- Evidence from staff meetings
- Training records for one dental nurse

We also held a telephone conference discussion with managers. The evidence submitted provided sufficient assurance that the previous breaches of regulations had been addressed. We did not visit the service on this occasion

Are services safe?

Our findings

At our inspection in April 2017 we found that the provider had not conducted appropriate checks of associate staff, for example those dentists and dental therapists not directly employed.

Disclosure and barring service checks of associate staff had not been carried out. It was not clear how the provider assured themselves that clinicians held current professional registration and indemnity insurance appropriate for their work.

Subsequent to the inspection we were given copies of current professional registration, indemnity cover and disclosure and barring service checks for all employed and contracted staff working at HMP Haverigg.

During this focused inspection, the provider explained how their personnel systems ensured that all staff were appropriately checked before carrying out patient care and treatment. They also shared an updated recruitment policy and informed us how checks were being carried out for all staff including potential locum dental clinicians. No permanent staff had been recruited, but we were given assurance that the policy would be followed for all future recruitment.

Are services effective?

(for example, treatment is effective)

Our findings

At the inspection in April 2017, we found that the trainee dental nurse had not received managerial or clinical supervision since commencing in post over 12 months earlier.

There was no evidence to demonstrate how the provider ensured the trainee dental nurse was suitably skilled and competent to carry out their role.

During this focused inspection, we were given details of the supervision arrangements and shown evidence that supervision was in place for the trainee dental nurse, who had recently fully qualified. However, dates for and copies of supervision evidence since April 2017 was not available, as it had been sent to the training provider for validation.

Are services caring?

Our findings

We did not inspect this key question during this focused inspection.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We did not inspect this key question during this focused inspection.

Are services well-led?

Our findings

At our inspection in April 2017, we found that the provider was not effectively supporting staff and monitoring the quality of the service. We found that:

- There was no evidence that complaints were monitored or reviewed, or that patient surveys and feedback were analysed or used to drive improvements in the quality and safety of the service.
- Management arrangements had changed but there was no evidence to demonstrate how Ferryhill Dental Health Centre managers were supporting staff at this branch location.
- There was no system in place to ensure that all staff providing care and treatment were appropriately checked by the provider.

The provider shared an action plan with CQC to show how it would ensure compliance with the regulations after the inspection. This included:

- Introducing and monitoring regular staff meetings and formalising supervision arrangements
- Implementing a quality assurance system of complaints
- Carrying out relevant disclosure and barring service checks and obtaining assurance of current professional registration and indemnity arrangements for clinical staff.

Staff meetings allowed an opportunity to share learning, and the HMP Haverigg team had visited prisons in the north east as part of improving shared learning and sharing good practice.

There had been no complaints submitted at HMP Haverigg since the inspection in April 2017, but the quality assurance process had been introduced into the other prison locations where Ferryhill Dental Health Centre delivered dental services. We saw a copy of the quarterly quality review of complaints at another prison location which had led to additional dental sessions being facilitated to reduce waiting times.

We were informed that patient feedback was used to improve the service where relevant. At HMP Haverigg 12 surveys had been received and analysed in 2017 and the feedback was all positive.

During this inspection, we were also given evidence to show how staff had made further service improvements. Staff developed a range of eye catching oral health promotion material, visited workplaces to speak with prisoners and also offered toothbrushes and toothpaste to all prisoners on request.