Care of Children on the Orthodontic Pathway

Birmingham Women's and Children's NHS Foundation Trust

Visit Date: 2nd October 2019

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Introduction

This report presents the findings of the review of Birmingham Women's and Children's NHS Foundation Trust that took place on the 2nd October 2019. The purpose of the visit was to review compliance with the following Quality Review Service (QRS) Quality Standards:

- Quality Standards for the Orthodontic Patient Pathway V2 D8

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Any immediate risks identified will include the Trust's proposal for actions to mitigate the risk and QRS response. Appendix 1 lists the visiting team that reviewed the services in the Birmingham Women's and Children's NHS Foundation Trust. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

This report describes services provided or commissioned by the following organisations:

- Birmingham Women's and Children's NHS Foundation Trust
- NHS England Specialised Commissioning
- NHS Birmingham and Solihull Clinical Commissioning Group

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation liaising, as appropriate, with other commissioners, including commissioners of primary care. The lead commissioner in relation to this report is NHS England Specialised Commissioning.

About the Quality Review Service

QRS is a collaborative venture between NHS organisations to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of QRS is available at www.qualityreviewservicewm.nhs.uk

Acknowledgments

Quality Review Service would like to thank the staff and service users and carers of Birmingham Women's and Children's NHS Foundation Trust for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

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Birmingham Children's Hospital Orthodontic Service.

The Birmingham Women's and Children's NHS Foundation Trust (BWC) manages the complex orthodontic care service based at the Birmingham Children's Hospital (BCH). This service provides care to patients requiring functional rather than cosmetic orthodontic treatment including patients born with cleft lip and palate including associated disorders. The service incorporates the West Midlands Regional cleft service for treatment of children with cleft palate and associated disorders.

The cleft service moved to BWC in 1998 and the West Midlands cleft service was formally set up in April 2000, as the first regional cleft service in the country.

There was a clear pathway of care between BWCH and the University Hospitals Birmingham NHS Foundation Trust at the Queen Elizabeth Hospital (QEH). Surgical care was provided at the QEH site. Surgeons from QEH had sessional commitments at BWCH to manage these pathways. Children transitioned to the adult service at around their 16th birthday (see later note on exact timing).

In 2015 the Birmingham Dental Hospital (BDH) moved from its site next to BCH, to its present site at Pebble Mill. Since the new dental hospital would have less clinical space after the move, the cleft orthodontic service was moved from BDH to BCH and the QEH. This service model was something which the cleft service had intended to implement since the initial setup of the West Midlands cleft service but was only implemented when the BDH move necessitated the change.

The Orthodontic service was led by a consultant orthodontist. There were two consultant orthodontists in the service, with the second having been appointed following the move of the service to BCH and the QEH.

At the time of the review, the West Midlands cleft service covered a population of approximately six million people, with a centralised cleft service model

There were expected to be about 120-130 newborn patients in 2019; this rate has increased since 2000; when the incidence was about 100 per year. There was also an increase in the movement of patients into the West Midlands, compared to 2000.

At the time of the review, there were 2,461 patients, aged 16 or under, on the cleft data base. This included: 114 complete bilateral patients (average 7 per year) and 278 unilateral patients (average 17 per year).

Outpatients

The care of orthodontic patients and children with cleft lip and/or palate was an outpatient service, based at the BCH site. The clinic is situated in the main outpatient area of the hospital.

The consultation clinics and treatment areas were all co-located in the same part of the outpatients service.

The main assessment and planning clinics, to agree treatment approaches, were held on Wednesdays with a multidisciplinary model of care in which staff were available in clinics for advice and consultation. The treatments agreed in these clinics were often undertaken on different dates in the same outpatient area.

Review visit findings

General Comments and Achievements

Patients[1] using the orthodontics and cleft service were likely to be attending for many years. They were well known to the service. The reviewers heard an overwhelmingly positive response to their experience of care and to the quality of service that patients, their carers and their families received.

The reviewers spoke to a number of children attending the service and to their families. These ranged from parents of very young children to teenagers and their carers. They described it as “an amazing service” and “absolutely fantastic” and said that “we will remain forever grateful”. One patient commented on the long waits but was very satisfied with the care received.

Patients particularly recognised the flexibility in appointments which minimised the impact of regular attendance on families and also on school absence. Parents and carers commended the Trusts approach to discounted car parking costs for which they were grateful.

The service had good working relationships with the QEH service for adults. Transition pathways were clearly identified, and the same staff at BCH cared for patients at QEH after transition, as staff held substantive contracts in one organisation and honorary contracts in the other. However, transition was viewed by the team as more than just a change of location, and a lot of effort was made to settle the patient into the new environment at QEH after transition.

Good Practice

1. The service had robust IT systems, which included both the CLIVE database and the PEPR portal. Reviewers were impressed by the quality and approach to integrating information systems into clinical practice.
2. Reviewers were impressed that the service had progressed to scanning of dental models, which would ultimately allow the service to move away from the long-term storage of plaster models.
3. Patients and their families told reviewers that they felt well informed by the service about their condition and their care. They appreciated the high quality of care they received. It was clear to the visiting team that patients heard a consistent message on their care and the care plan from all members of the clinical team.
4. Laboratory appliances used by the service were of a good quality.
5. Reviewers were impressed by the use of Cleft Lip And Palate Association (CLAPA) volunteers in the outpatient clinic.
6. The transition model in place for patients at age 16 was excellent. The use of a traffic light (red/amber/green) approach, discussion at multi-disciplinary (MDT) meetings and the timing of transition to suit both the patients emotional development, and their current treatment plan, (so that transition did not happen in the middle of an active treatment phase), were all highly commended.
7. There was a breast-feeding room in the outpatient clinic. This was clearly patient-and-family focussed

Immediate Risks

There were no immediate risks identified in this service during the visit.

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[1] *Note that in this report the term patient refers to a child attending the service. Almost always children will attend with a carer or family member. Comments attributed to patients’ views and experiences are intended to include the wider carer/family experience.*

Serious Concerns

1. Reviewers were seriously concerned that there were significant gaps in the recorded training of staff in safeguarding. One of the two orthodontists, two of the three senior dental nurses and one of the three dental nurses did not have Level 2 adults safeguarding recorded. Reviewers identified that whilst this was a service for 0-16 year olds, those accompanying children to appointments may also be vulnerable, and this could be an indicator of underlying safeguarding issues for children. The review team are aware that the Trust standard is for clinical staff to have achieved Level 3 adult safeguarding training.
2. Reviewers identified that given the number and range of staff who had not received this training, clinics could be staffed entirely by a team that had no recorded training in the expected level of adult safeguarding
3. The training in child protection Level 3 for one of the three senior dental nurses had expired in July 2017.
4. One member of staff had no training in medical gases, and their healthcare records training had expired in October 2017.

Concerns

1. There was no operational policy specific to this service. There were very few individual documents available that described the local operational detail for this service.
2. There were no clinical guidelines specific to the BCH service in place.

   Clinical guidelines, operational policies, procedures and work instructions provide clarity for staff, form robust induction documents and ensure consistency of quality of care. They also form a clear framework for arbitration if there were disagreements over approach and care models. Reviewers felt the lack of these policies and procedures was a clear barrier to effective working.
   Reviewers noted that writing a bespoke version of policies and clinical guidelines at this stage in the BCH service may be difficult as clinical practice is already established and may vary. However, reviewers identified that an initial step might be to adopt and localise policies from an established service and use this as a baseline to develop a local policy and procedure system.
3. Whilst leadership roles were identified (e.g. the lead orthodontist), there was little clarity on what this meant in operational detail. This could be clarified in an operational policy, but it is important to ensure that those with a leadership role understand their responsibilities, and that those working alongside them have clarity as to whether these duties are being discharged.
4. There was insufficient capacity for dedicated senior dental nursing leadership. Reviewers observed that all senior nurses had allocated clinical duties which took up most of their time. This left little capacity for service problem solving, leadership and planning. There was no protected time for procurement and stock ordering.
5. The service did not have a recent skills mix review that aligned to the current workload. Reviewers identified that the service appeared to have sufficient staffing for the tasks required, but it was unclear how these roles had been derived or whether staff were being effectively utilised.
6. The service did not have identified competences for roles. There was no available training plan to maintain competences and skills. This would be an essential part of the skills mix review.
7. Reviewers looked at the function of the 'MDT' meeting and considered that it did not operate in the traditional sense of an MDT. At the time of the visit, the clinics were parallel clinics where a range of professionals saw patients and called upon others for their opinion where required. In a true MDT, a range of healthcare professionals all meet to give their input to an individual patient's treatment and care plan.
8. Dental models were scanned into the electronic system by consultant orthodontists. The initial plan was for this scanning to be done by the dental nurses, but lack of nursing capacity (see concern 4 above) had prevented this.

Reviewers identified that the task of scanning is one that an individual must be trained for, and one which regular quality assurance must be provided; but they felt that it is not necessarily a clinical task. Removing this administrative task from the consultants would allow for additional clinical capacity.

9. There was no identified systematic process for the service to gather and act on patient feedback and comments.

Further Consideration

1. The scanner used for scanning dental models was situated in one of the clinics. This meant that it was inaccessible for significant periods of time.
2. The service had two x-ray machines which were in use in other outpatient clinics. However, reviewers were told they were not in use in the Orthodontic clinics because the clinic rooms were needed for consultations. This meant that, for those patients who may not otherwise need to attend the X-ray department, they were therefore required to join an additional queue in radiology which added extra time to their visit.
3. The service level agreement with the off-site dental laboratory had expired in 2017. There was therefore not a valid contract in place for the provision of this service. The visiting team were unable to identify copies of any other contracts in place so were unsure if this was an isolated instance.
4. There had not been any meetings to discuss the performance against contract or quality of service provision with off-site services.
5. Reviewers were told that at the weekly 'MDT' meeting each specialist wrote a letter after the consultation. Reviewers understood that multiple letters could then be generated for the same patient from the same clinic visit. The service should consider whether one combined letter might be more effective.
6. The Medical Devices Directive (MDD) advice slip included with the dental models and appliances should be given to the patient for their reference. Reviewers understood that this did not happen.
7. The visiting team noted that impressions taken on-site were not marked as disinfected before transfer to the laboratory, and therefore the laboratory sterilised each impression on receipt. Reviewers expressed a concern that if the impression/appliance had already been sterilised, repeating the process could compromise the integrity of the impression. The service should consider whether this information is appropriately communicated to the laboratory in all cases; and, whilst this would not be ideal, also consider using the same disinfectant solution as the laboratory if dual disinfection is to continue.
8. It was unclear to the review team whether the service was well integrated into the wider Trust. It was noted that some links for clinical processes already exist (e.g. servicing dental braces); however, the Trust and the service management team will want to develop a stronger awareness by the service of the wider Trust, for example in those services at BWCH with strong operational policies and processes.
9. The Trust had made efforts to ensure that the waiting room was child friendly, but reviewers were unable to see any evidence of this being extended to the clinic and treatment rooms. Whilst the rooms where children were seen, examined and treated had some pictures on the walls and windows; reviewers felt that more was required to make the area child friendly and to minimise the impact of a clinical environment on younger patients.
10. The waiting room had a large vaulted ceiling which contributed to poor acoustics and exacerbated the background noise. Reviewers identified that patients or family members who have behavioural or autistic spectrum disorders, or people who have hearing problems, find this environment challenging.
11. Reviewers were unable to identify a recent meeting with commissioners where the quality of the service and service developments were reviewed. The visiting team identified that it would be helpful for the service leads to request one.
12. Although the initial general information leaflet was excellent, patients would also value an individual care plan.

13. Information on wider support services provided by the hospital such as social workers and spiritual support should be made available and arrangements for access should be visible in the clinic.
14. There was no system in place for monitoring and reviewing response times to queries from patients. Setting targets and monitoring response times would be useful.

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APPENDIX 1 Membership of Visiting Team

Visiting Team		
Diane Bell	Specialist Dental Nurse	University Hospitals Bristol NHS Foundation Trust
Samantha Bunn	Principal Maxillo Facial Prosthetist / Laboratory Manager	The Shrewsbury and Telford Hospital NHS Trust
Mr Scott Deacon	Lead Consultant Orthodontist	University Hospitals Bristol NHS Foundation Trust
Amy Harrison	Service Manager	Quality Review Service
Fiona Kociuruba	Senior Dental Nurse	The Shrewsbury and Telford Hospital NHS Trust
Jane Williams	Service User Representative	Quality Review Service

QRS Team		
Tim Cooper	Director	Quality Review Service

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APPENDIX 2 Compliance with the Quality Standards

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varies depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No, but', where there is real commitment to achieving a particular standard, than a 'Yes, but' where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 - Percentage of Quality Standards met

Details of compliance with individual Quality Standards can be found below.

Service	Number of Applicable QS	Number of QS Met	% met
Specialist Orthodontic Service	36	20	56%
Commissioning	2	1	50%
Health Economy	38	21	55%

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Specialist Orthodontic Service

Ref	Standard	Met?	Comments
YN-101	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service, such as opening hours and clinic times b. Staff and facilities available c. How to contact the service for help and advice, including out of hours arrangements d. Range of other services available locally	Y	Reviewers saw good patient information. The cleft booklet in use was written some years previously but appeared to provide good information for patients. The service might want to check all the information remains valid.
YN-102	**Condition-Specific Information** Information for patients and their carers should be available covering, at least: a. Brief description of their condition and its impact b. Possible complications and how to prevent these c. Pharmacological and non-pharmacological therapeutic and rehabilitation interventions offered by the service d. Possible side-effects of orthodontic interventions, especially if there is poor compliance with the treatment plan e. Symptoms and action to take if unwell f. Self-care and dental hygiene g. Health promotion, including smoking cessation and healthy eating h. Emotional health and wellbeing i. Sources of further advice and information including: i. how to access advice on alternative treatments ii. obtaining a second opinion. iii. costs of any treatment if applicable. iv. after care arrangements and costs if applicable.	Y	The visiting team noted that the service did not have information for h(ii) - 'seeking a second opinion'. However, they noted this was a rare event and recognised that this was available as an option for patients.
YN-103	**Plan of Care** Each patient, and where appropriate, their carer should discuss agree and consent to the plan of care, and should be offered a written record covering at least: a. Agreed goals b. Self-management c. Planned treatments d. Early warning signs of problems, and what to do if these occur e. Who to contact with queries or for advice f. Care after treatment including retention period. The plan of care should be communicated to the patient's primary care dentist and /or GP and to relevant other services involved in their care.	N	An individual plan of care was not given to patients. However, reviewers noted that there was a clearly documented generic pathway, and patients felt very well informed on how this applies to them.

Ref	Standard	Met?	Comments
YN-105	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available, then the timescales for a response should be clear. Response times should be no longer than the end of the next working day. All contacts for advice and a sample of actual response time should be documented.	N	Patients did have contact details for the service. However, the service had not set out the response times that patients should expect. The service did not measure or record response times and was unable to provide assurance that current response times met this standard and were responsive to patient needs and those of their carers.
YN-193	**Communication Aids** Communication aids should be available to enable patients to participate as fully as possible in decisions about their care.	Y	
YN-194	**Environment** The environment should be welcoming and suitable for all patients, carers and visitors including: a. Appropriate signage b. Suitable lighting c. Wheel-chair accessibility	N	The Trust had made efforts to ensure that the waiting room was child friendly, however reviewers were unable to see any evidence of this being extended to the clinic and treatment rooms. The rooms where children were seen, examined and treated had little that minimised the impact of a clinical environment. The waiting room had a large vaulted ceiling which contributed to poor acoustics and exacerbated the background noise. Reviewers identified that patients or their family who may have behavioural or autistic spectrum disorders, or people who had hearing problems, may have found this environment challenging.

Ref	Standard	Met?	Comments
YN-195	**Transition to Adult Services and Preparation for Adult Life** Young people approaching the time when their care will transfer to adult services should be offered: a. Information and support on taking responsibility for their own care b. The opportunity to discuss the transfer of care with paediatric and adult orthodontic services c. A named coordinator for the transfer of care d. A preparation period prior to transfer e. Written information about the transfer of care including arrangements for monitoring during the time immediately afterwards f. Advice for young people going away from home including: i. registering with a GDP and GP ii. how to access emergency and routine care iii. how to access support from their specialist service iv. communication with their new GDP and GP	Y	The review team saw that the transition model was an excellent approach to patients moving between services. The reviewers noted that the orthodontic clinical staff would be the same at both BCH and QEH. Reviewers also noted that transition was planned around current treatment schedules and was timed to avoid transition during an active treatment phase.
YN-196	**Discharge Information** On discharge from the service, patients and their carers should be offered written information covering at least: a. Care after discharge b. Ongoing self-management of their condition c. Possible complications and what to do if these occur d. Who to contact with queries or concerns	N	
YN-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. HealthWatch or equivalent organisation h. Relevant voluntary organisations providing support and advice	N	Reviewers noted that the service did not routinely provide information to patients and their carers on b. Independent advocacy services d. Social workers e. Benefits advice f. Spiritual support g. HealthWatch or equivalent organisation
YN-198	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. What to do in an emergency c. Access to a Carers' Programme (if appropriate) d. Services available to provide support	Y	

Ref	Standard	Met?	Comments
YN-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about the treatment and care they received b. Mechanisms for involving patients and carers in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of patients and carers	N	Reviewers noted that patients were very involved in transition decisions. However, reviewers were unable to see a systematic process for receiving feedback from patients and involving patients in decisions regarding the organisation of the service. Reviewers were unable to identify how service user views and outcomes of any feedback had led to changes in the service.
YN-201	**Lead Clinician** A nominated lead clinician should have responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service.	Y	Reviewers noted however that there was no documented system for identifying this. This should be changed as there are reminders regarding mandatory training which are sent via email
YN-202	**Staffing Levels and Skill Mix** Sufficient staff with appropriate competences should be available for the: a. Number of patients usually cared for by the service and the usual case mix of patients b. Service's role in the patient pathway and expected timescales c. Assessments and therapeutic and/or rehabilitation interventions offered by the service d. Infection prevention and control to prevent physical, chemical and microbiological contamination in the surgery or laboratory e. Use of preparations and equipment required for these assessments and therapeutic interventions f. Urgent review within agreed timescales (if applicable). An appropriate skill mix of staff should be available including dentists, orthodontic therapists, dental nurses, dental and clinical dental technicians and other staff required to deliver the range of assessments and therapeutic interventions offered by the service. Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	The review team noted that there were 63 hours of senior dental nurse and 60 hours of dental nurse available each week. Reviewers identified that the service did not have a clear assessment of skills mix and competencies to identify how the number of staff on each shift with the correct competencies had been derived.

Ref	Standard	Met?	Comments
YN-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place.	N	There was no evidence of service competencies and training plans available. Note that this also links to YN-202
YN-298	**Competences – All Dental Staff** All dental care professionals and staff, working in the service should have competences appropriate to their role in: a. Safeguarding children and/or vulnerable adults b. Recognising and meeting the needs of vulnerable children and/or adults c. Dealing with challenging behaviour, violence and aggression d. Consenting patients for treatment e. Mental Capacity Act and Deprivation of Liberty Safeguards f. Resuscitation g. IR(ME)R regulations h. Infection prevention and control i. Information Governance including ensuring confidentiality of patient information and images	N	Reviewers we concerned that there was a significant gap in adult safeguarding training to level 2. One of the two orthodontists. Two of the three senior dental nurses did not have level 2 adults safeguarding. One of the dental nurses had not received adult safeguarding level 2 training. Reviewers identified that whilst this was a service for 0-16 year olds, those accompanying children to care appointments may be also vulnerable and this also may be an indicator of underlying safeguarding issues for children. Reviewers identified that it was likely that, given the number and range of staff with this training missed, clinics could be staffed entirely by a team that had no training in adult safeguarding at level 2. Reviewers also identified that one senior member of staff had Child Protection Level 3 training that had expired in July 2017. One member of staff also had no training in medical gasses, and their healthcare records training expired in October 2017.
YN-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y	Reviewers noted that this should also be included in a wider review of skills mix identified in standards YN-202

Ref	Standard	Met?	Comments
YN-301	**Support Services** Timely access to an appropriate range of support services should be available.	Y	The service received an efficient and effective service from its partners off-site. Reviewers were only shown the contract for service provided by the off-site dental laboratory. It was noted that this contract had expired in December 2017. the Trust continued to receive a good service despite this. The service may wish to review all of its off-site contracts to ensure they are valid and provide assurance of continuity of service
YN-401	**Facilities** Facilities available should be appropriate for the assessments, therapeutic and/or rehabilitation interventions offered by the service for the usual number and case mix of patients. Facilities and equipment should comply with all relevant Standards and should ensure: a. Appropriate privacy, dignity and security for patients b. Protection of other patients, staff and members of the public from radiation and radioactive sources c. Appropriate separation of children and adults *Notes:* *1. Required facilities and equipment are not strictly defined but should be clean and appropriate for the usual number and case mix of patients cared for by the service.* *2. This QS links to YN-194*	Y	However Please see comments in YN-194

Ref	Standard	Met?	Comments
YN-402	**Equipment** Timely access to equipment appropriate for the service provided should be available. The service should have arrangements for equipment management covering: a. Procurement and management of equipment and consumables b. Installation assurance c. Calibration, operation and performance of equipment d. Cleaning standards e. Equipment maintenance (service contracts and maintenance schedules) covering planned maintenance and breakdown or unscheduled maintenance f. Contingency plans in the event of equipment breakdown g. Monitoring and management of equipment failures and faults h. Ensuring safety warnings, alerts and recalls are circulated and acted upon within specified timescales i. Programme of equipment replacement and risk management of equipment used beyond its replacement date *Notes:* *1. As QS YN-401.* *2. These arrangements should link with Trust-wide arrangements for governance of medical equipment.* *3. Timely is not strictly defined but availability of equipment, including consumables and process for decontamination should not unreasonably delay patient pathways or adversely affect patient outcomes and experience.*	Y	Reviewers noted that the procurement was nurse led. There was no identified or protected time for this. Reviewers saw that the service had two x-ray machines in clinics. These were not in use as it interrupted clinic flow. However, reviewers identified that these machines were appropriately maintained.
YN 499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	Y	

Ref	Standard	Met?	Comments
YN-501	**Initial Referral and Assessment Guidelines** Guidelines on referral and assessment should be in use covering the usual case mix of patients referred to the service. Guidelines should cover at least:- a. Criteria for acceptance b. Oral health assessment c. Assessment of malocclusion and treatment need *Notes:* *1. Guidelines should be based on national guidance, (including NICE, General Dental Council and British Orthodontic Society where available), and the commissioned local pathway and should be localised to show how national guidance will be implemented in the local situation. Use of national guidance without consideration of local implementation is not sufficient for compliance with this QS.* *2. Referral guidelines should be consistent with QS YA-501* *3. This QS links to commissioning YZ-602* *4. For newly diagnosed babies the guidelines should include referral to a cleft palate team within 24hrs*	Y	
YN-502	**Clinical Guidelines** Guidelines on management of the usual case mix of patients referred to the service should be in use covering, at least: a. Therapeutic interventions offered by the service b. Monitoring and follow up, including retention period c. Arrangements for liaison with other services *Notes:* *1. As QS YN-501.* *2. The retention period may vary depending on clinical need* *3. Services should be able to demonstrate that guidelines have considered 'parity of esteem' The Mandate, Department of Health 2017*	N	There was no guideline in use defining how the service managed clinical interventions and patient care.
YN-503	**Consent Procedure** A Dental/Orthodontic Service consent procedure should be in use. This procedure should be based on the Trust (or equivalent) consent procedure and should have appropriate additional detail to ensure compliance with the British Orthodontic Society, Professional Standards for Orthodontic Practice 2014 and General Dental Council.	Y	

Ref	Standard	Met?	Comments
YN-504	**Imaging Guidelines** Imaging Guidelines should be in use covering: - a. Roles and responsibilities of staff b. Use of equipment c. Initial and final reporting timescales d. Documentation e. Storage and retrieval *Notes:* *1. Monitoring of agreed timescales is covered in QS YN-701.* *2. Guidelines should be consistent with the latest Ionising Radiation (Medical Exposure) Regulations.*	Y	Trust wide policies, including local rules, for the use of imaging equipment were in place.

Ref	Standard	Met?	Comments
YN-595	**Guidelines on Transition and Preparing for Adult Life** Guidelines on transition of young people from paediatric to adult services should be in use covering, at least: a. Involvement of the young person and, where appropriate, their carer in planning the transfer of care b. Involvement of the young person's primary care dentist and/or general practitioner in planning the transfer c. Joint meeting between paediatric and adult services in order to plan the transfer d. Allocation of a named coordinator for the transfer of care e. A preparation period prior to transfer f. Arrangements for monitoring during the time immediately after transfer. g. Advice for young people going away from home, including: i. registering with a GP or general dental practitioner ii. how to access emergency and routine care iii. how to access support from their specialist service. iv. communication with the young person's new GP or general dental practitioner *Notes:* *1. This QS may not be applicable to services where the same clinical staff provide care for both children and adults.* *2. It applies only to services where significant numbers of young people transfer from paediatric services or where the responsible clinical staff change when the young person becomes an adult.* *3. The QS applies to both paediatric and adult service and transition guidelines should be agreed between relevant paediatric and adult services.* *4. Joint meetings between paediatric and adult services may be in the form of a phone or video-conference, so long as the young person is involved.* *5. The General Dental Practitioner and GP should be informed / given the opportunity to be involved in the transition of young people from paediatric to adult services.* *6. Transition may be to the care of the general dental practitioner only, without involvement of specialist services (QS XA-101).* *7. Guidelines should specifically cover arrangements for students studying away from their local service.*	Y	

Ref	Standard	Met?	Comments
YN-596	**Transfer of Care** Protocols should be in use covering: a. Handover of care between clinical teams b. Transfer of care following an in-patient admission *Notes:* *1. Training on the implementation of transfer of care protocols is covered in the QSs for individual clinical services or departments*	Y	Note that standard YN-596 b. is not applicable to this service.
YN-597	**Discharge Guidelines** Guidelines on discharge from the service should be in use. *Notes:* *1. As QS YN-501. Guidelines should be based on criteria for discharge from the service agreed with commissioners (QS YZ-602).*	N	There were robust and clear protocols for transition. However reviewers were unable to identify guideline for patients being discharged from the service by any other route (e.g. at end of treatment).
YN-599	**Care of Vulnerable People** Guidelines for the care of vulnerable children, young people and adults should be in use, in particular: a. Use of sedation b. Consent, Mental Capacity Act and the Deprivation of Liberty Safeguards c. Safeguarding d. Information sharing *Notes:* *1. All patients may be vulnerable and deserve the highest possible quality of care. Some groups of patients are, however, particularly vulnerable and may be less able than others to voice their wishes and any concerns. These people need extra consideration. These groups include looked after children, people with learning disabilities, mental health problems or dementia, victims of neglect or of sexual or domestic violence, and those people who are particularly frail or nearing the end of their life.* *2.* This is a linking QS and will not be reviewed in detail. Any lack of compliance seen during review visits will, however, be noted.	N	A significant number of staff did not have at least level 2 adult safeguarding training.

Ref	Standard	Met?	Comments
YN-601	**Service Organisation** The service should have an operational procedure describing the organisation of the service including, at least: a. Expected timescales for the patient pathway, including initial assessment, start of therapeutic interventions and review, and arrangements for achieving and monitoring these timescales b. Responsibility for giving patient and carer information at each stage of the patient journey c. Arrangements for responding to patients' queries or requests for advice by the end of the next working day d. Arrangements for follow up of patients who 'do not attend' e. Arrangements for multi-disciplinary discussion of appropriate patients f. Arrangements for accessing specialist advice and liaison with the Cleft Centre Team g. Arrangements for liaison with key support services (QS YN-301) h. Arrangements for maintenance of equipment (QS YN-402) i. Arrangements for risk management. j. Responsibilities for IT systems (QS YN-499)	N	Reviewers were not able to see an operational policy for the service. Reviewers were shown an appointment booking protocol in the form of a chart of which patient need to see which clinicians, but this did not describe how those appointments should be booked. Reviewers were able to see a Trust DNA policy and a Trust medical equipment policy. Reviewers identified that having a clear operational policy with clarity on processes and pathways of care will be helpful to ensure consistency of care and avoid misunderstandings.
YN-699	**Liaison with Other Services** Review meetings should be held at least annually with key services to consider liaison arrangements and address any problems identified. *Notes:* *1. This QS relates to those services with which liaison is particularly important to ensure an efficient, high quality patient journey. These services should be listed in QS YN-301 but annual review meetings with all services required in QS YN-301 may not be necessary.* *2. Meetings may be part of a Trust-wide meeting so long as operational issues specific to the service are discussed. This QS is in addition to day to day liaison arrangements and should involve staff with management responsibility for the service.*	N	There was no evidence available that review meetings had taken place. Reviewers identified that the out of date agreement with the off-site dental laboratory was a key indicator of this standard not being met.

Ref	Standard	Met?	Comments
YN-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source of appropriateness of referrals b. Number or assessments, urgent reviews and therapeutic interventions undertaken by the service c. Number of treatments started within 18 weeks of initial assessment if patient meets necessary referral criteria d. Types of appliance used e. Outcome of assessments and therapeutic interventions concluded (including number completed, abandoned and discontinued) f. Number of discharges from the service and type of care after discharge g. Key performance indicators appropriate to the service	N	Reviewers saw that the service submitted data to the CLIVE data base and were impressed by the systems in use in the service. There was no regular monitoring of data by the service. Reviewers were told of a regular MDT meeting which appeared to be a business meeting, reviewers saw the agenda for this but no papers. This meeting appeared to be the basis for the service to consider this, and some data were considered; however this did not appear to be a systematic process.
YN-702	**Audit** The services should have a rolling programme of audit of compliance with: a. Evidence-based clinical guidelines (QS YN-500s) b. Standards of record keeping c. Timescales for key milestones on the patient pathway *Notes:* *1. Timescales across the patient pathway may be nationally or locally agreed with commissioners.*	Y	
YN-703	**Key Performance Indicators** Key performance indicators (QS YN-701) should be defined which are specific for the service and should be reviewed regularly with Trust (or equivalent) management and with commissioners. *Notes:* *1. Regularly is not strictly defined but should ensure that key performance indicators are reviewed in line with the locally agreed assurance framework to ensure that the service is monitored, and actions taken.*	Y	
YN-704	**Research** The service should actively participate in research relevant to the care of their patients. *Notes:* *1. Participation can include comparative analysis, benchmarking or similar outcome reviews*	Y	This has recently been progressed.

Ref	Standard	Met?	Comments
YN-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of and implementing learning from positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of and implementing learning from published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency *Notes:* *1. This QS is about staff within the service learning together. Uni-disciplinary meetings or management meetings are not sufficient for compliance with this QS.* *2. Arrangements for MDT review and learning should be formalised and clearly communicated to staff.*	N	As discussed in YN-701, the Friday MDT meeting does meet to review areas of concern. However the elements of the standard identified here do not form part of the formal agenda.
YN-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures. *Notes:* *1. Specific documentary evidence of compliance is not required. This QS will be determined from the other documentary information provided.* *2. Copies of the organisations document control policies are also required for compliance with this QS.*	Y	This standard is met in relation to the small number of Trust-wide policies and procedures seen by the reviewers; however this is not applied locally as there are no local policies available.

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Primary Care

Ref	Standard	Met?	Comments
YA-501	**Primary Care Guidelines** Guidelines on primary care management of orthodontics should be in use, covering at least the role of the primary care dentist in: a. Indications for urgent and routine referral to a specialist service and information to be sent with each referral i. Early referral for those with cleft lip, palate of other craniofacial anomalies ii. Referral for children with maxillary/ mandibular disproportion. iii. Transfer and referral of difficult cases where there has been conflict or disagreement of treatment options available. b. Management of acute complications as well as longer term follow up. c. Integrated care arrangements	N/A	The service does not deliver services in Primary Care, but does receive referrals from primary care GP and GDP

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Commissioning

Ref	Standard	Met?	Comments
YZ-602	**Commissioning of Services** Services for each patient pathway should be commissioned including, for each service: a. Range of assessments, therapeutic and/or rehabilitation interventions offered by the service b. Criteria for referral to and discharge from the service c. Whether the service cares for children, adults or both d. Key performance indicators	N	Commissioning of this pathway was undertaken by Specialised Commissioning from NHS England. There was little specific understanding of the detail of this service.
YZ-701	**Quality Monitoring** The commissioner should monitor key performance indicators and aggregate data on activity and outcomes from the service at least annually.	Y	However, there were no formal quality monitoring meetings in place. Oversight of the contract was activity based.

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