East Cheshire NHS Trust

RJN

Community dental services

Quality Report

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This report describes our judgement of the quality of care provided within this core service by East Cheshire NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by East Cheshire NHS Trust and these are brought together to inform our overall judgement of East Cheshire NHS Trust

Summary of findings

Ratings

Overall rating for Community Dental Services	Good 
Are Community Dental Services safe?	Good 
Are Community Dental Services effective?	Good 
Are Community Dental Services caring?	Good 
Are Community Dental Services responsive?	Good 
Are Community Dental Services well-led?	Good 

Summary of findings

Contents

Summary of findings

Overall summary

East Cheshire NHS Trust provides a range of specialised dental services for people with complex or special needs, vulnerable people and those who find it difficult to access general dental services because of their particular needs.

The community dental service had systems and processes in place to keep patients and staff safe. There were robust processes to identify and manage potential risks to patients, including the use of effective infection control measures. Each clinic was clean and well maintained.

Patients told us that they were treated with dignity and respect when accessing and receiving treatment. Patients and their representatives spoke highly of the care provided and said that care was delivered by staff who were compassionate and understanding of their needs. There was good collaborative working between the service and other healthcare services to ensure good patient outcomes.

Initiatives had been established to improve the service and to use the resources effectively. Staff we spoke with felt supported in their roles and that their managers were approachable and accessible.

Summary of findings

Background to the service

East Cheshire NHS Trust provides a range of specialised dental services in East Cheshire, covering an area from Northwich in the west to Macclesfield in the east, Handsforth in the north and Nantwich in the south, across a population of approximately 470,000.

The Community Dental Service includes:

- Behavioural management
- Sedation – inhalation and intravenous
- General anaesthesia
- Domiciliary care (home visits)
- Dental access services
- Out-of-hours dental services
- Special care dentistry
- Paediatric dental services
- Minor oral surgery
- Oral health promotion and prevention programmes.

During our visit we visited three centres in Crewe, Macclesfield and Northwich. We spoke with four patients who used the service and two relatives and carers. We spoke with 14 members of staff, who included the clinical director, business manager, dentists, dental nurses and administration staff.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, Director of EJ Consulting Ltd: Bradford Hospitals NHS Foundation Trust.

Team Leader: Helen Richardson, Care Quality Commission

The inspection was carried out by a CQC inspector with remote access to support and advice if required from our national professional adviser in dentistry.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection programme of East Cheshire NHS Trust.

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well led?

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We held a listening event in Macclesfield on 9 December 2014 when people shared their views and experiences of community dental services. Some people also shared their experiences by email or telephone. We carried out an announced visit on 11 December 2014.

During the visit we spoke with a range of staff who worked within the service. These included the clinical director, business manager, dentists, dental nurses and administration staff. We observed how people were being cared for and reviewed care or treatment records of people who used the services. We met with people who used the services and with carers, who shared their views and experiences of the core service

Summary of findings

What people who use the provider say

During our inspection we visited three centres in East Cheshire and spoke with four patients who used the service and two relatives and carers.

Patients told us that staff were responsive and understanding and 'went the extra mile' to meet their needs. Patients felt that they were listened to and given clear explanations and information to make informed choices about the care options offered.

Relatives we spoke with felt reassured that their children were in safe hands. They were pleased to learn that the same dentist would be providing their treatment when they attended the hospital for dental treatment under general anaesthetic. One relative said that 'nothing was rushed and they gave lots of reassurance and answered my questions'. A patient we spoke with said: ''I was delighted when I arrived and saw it was the same dentist. I was petrified before, but as soon as I saw him [the dentist] I knew I would be alright.''

Good practice

Our inspection team highlighted the following areas of good practice:

- The community dental service ran an oral hygiene education programme that fed into national data to improve children's oral health nationally.
- Staff responded well to people with particular special needs.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Not applicable

East Cheshire NHS Trust

Community dental servicesCommunity Dental Services

Detailed findings from this inspection

The five questions we ask about core services and what we found

Good

Are Community Dental Services safe?

By safe, we mean that people are protected from abuse

Summary

Safety was a priority for the community dental service. There were systems and processes in place to keep people safe. Mechanisms were in place to identify, manage and control risks to patients.

There were very few incidents; however, we saw evidence that incidents were reported and that there was learning from them.

Each centre was very clean and well maintained. The processes for decontamination and sterilisation of dental instruments complied with Department of Health guidance.

Detailed findings

Incidents, reporting and learning

- The dental service used the trust-wide electronic system for reporting incidents. This allowed staff to report all incidents, including near misses, where patient safety may have been compromised. Between June 2014 and December 2014, there were 255 incidents reported within the whole trust, but 12 occurred that related to the dental service. It was clear that all had been investigated thoroughly and actions put in place where appropriate. Staff we spoke with were clear about actions that had been taken by their manager as a result of incidents.
- Information sought from other regulatory bodies did not raise any concerns regarding dentistry provision within the service or regarding individual dentists.

Cleanliness, infection control and hygiene

- All the premises we visited were visibly very clean. A patient told us: "I have been coming here for about five years. It always looks amazingly clean." All the clinics were cleaned by a contractor employed centrally by the trust. The trust had a system of audits in place to ensure that the premises were kept clean. We saw a copy of one of these at Weston clinic, which confirmed that high standards were being maintained.
- All the clinics we saw had on-site designated decontamination rooms. All except one complied with Department of Health guidelines HTM 01-05 (a guidance document released by the Department of Health to promote high standards of infection control). However, this had been recognised and the one site had good procedures in place to mitigate the risk to patients. The risk was included on the local risk register and had been escalated to the trust decontamination lead for investigation through the trust's decontamination group and appropriate risk management process.
- We spoke with staff and reviewed the arrangements for infection control and decontamination procedures. Staff were able to demonstrate and explain in detail the procedures for the cleaning of dental equipment and for the transfer and processing of instruments to and through the decontamination rooms. Following sterilisation, all instruments were stored in pouches and date stamped in line with best practice. There were checking systems in place to ensure that supplies of sterilised instruments were in date.
- In each clinic we visited, we asked the dental nurse to demonstrate the procedures for decontamination and sterilisation of used dental instruments. Staff demonstrated an in-depth knowledge of HTM 01-05 and confirmed that they had access to personal protective equipment to undertake their roles when supporting patients during their treatment. Patients told us that treatment rooms were clean and that staff had worn appropriate uniform such as gloves, visors and masks during treatment, and we saw that this was the case. We saw that records were maintained of all the safety checks of decontamination equipment undertaken on a daily basis to ensure that equipment was effective and fit for purpose prior to use.
- We saw that sharps bins were all dated and none were overfull. The dental nurses confirmed that only the dentists handled sharps, thus reducing the risk of injuries.
- The service had arrangements in place with contractors for the disposal of dental waste such as extracted teeth, amalgam, radiological waste, sharps and other products.

Maintenance of environment and equipment

- The dental nurses were responsible for cleaning the treatment and decontamination rooms. There was a daily list in place for each, which was signed as evidence that it had been cleaned and checked. The work surfaces, chair and light were cleaned in between each patient. We saw that the light and the control panel for the chair had disposable covers; these were changed between each patient. Storerooms in the clinics were well lit, clean and in good order. Supplies were stored at the appropriate height for safe access.
- Legionella testing was done by the trust's estates department. We saw certificates demonstrating that this had been done. In addition, each centre had a checklist, which was completed and signed daily to ensure that taps were run, dental lines were flushed daily and toilets were flushed regularly so that the legionella bacteria did not have the opportunity to thrive in standing water.

Medicines management

- Emergency equipment was readily available and included medications, oxygen and a defibrillator. We saw that audit checks had been carried out regularly to check on the resources and the expiry dates of the medicines and equipment. Most of the nurses we spoke with were able to demonstrate how the equipment worked and that they were able to set it up quickly, should it be needed in an urgent or emergency situation. One was unable to set up the oxygen with a mask quickly, but realised that this could be critical and assured us that they would ensure they would be able to complete this task.
- Staff had access to the trust's medicines policy. There were very few medicines kept within the clinics. However, those that were there were stored safely. We checked a random sample of medicines. Expiry dates were checked regularly. All the medicines we saw were within date. The dental access clinics that administered

intravenous (IV) sedation stored a small amount of controlled drugs in order that they could be administered. These were stored safely and reconciled correctly.
- Medical gases, for example oxygen and nitrous oxide, were stored in locked cupboards, unless they were in use. The cylinders in use were clearly labelled and were transported around the clinic on a standard trolley to minimise the risk of injury from handling them.

Safeguarding

- Staff, including receptionists, were aware of safeguarding procedures and what may constitute a safeguarding concern. Safeguarding featured as a topic for discussion in staff meetings. We saw that staff had received training at induction and safeguarding was also included in the staff's mandatory training in accordance with the trust's policy. Staff we spoke with during our inspection demonstrated understanding and knowledge of the action they should take if they had a suspicion or evidence of abuse. For example, one dentist told us about a safeguarding alert to the local authority that they had raised when they found that a pre-school child required multiple dental extractions due to severe dental decay.

Records systems and management

- Patients' records were mostly in electronic format and access to these was via a swipe card and secure password. Paper records were stored in locked cabinets to ensure confidentiality. Records included essential information such as allergies, medical history and current medication being taken. They also included treatment plans and evidence of discussions with the patient or their parent or carer. Paper records contained completed consent forms, completed medical history forms and correspondence such as referral letters.
- We looked at staff records and saw that appropriate checks had been completed prior to employment, such as checking professional registration and disclosures to ensure that people were cared for by staff with the appropriate qualifications and who were fit for employment.

Lone and remote working

- The dental service offered a domiciliary (home visiting) service for those who were not able to attend the surgeries, for example for patients who were housebound because they were infirm or had profound disabilities. The visits included seeing people who lived in residential community settings, for example in care homes. We saw a comprehensive standard operating procedure, dated April 2014, that detailed those patients who were appropriate for domiciliary visits and how their care was planned and carried out. The dentist never visited sites remote from the surgery alone; a dental nurse always accompanied them. Each centre had a domiciliary kit, which included equipment required for check-ups and basic treatment. In addition, each kit contained emergency medicines, a sealed box for safely transporting contaminated instruments and portable oxygen. There was a system for checking these kits; we saw signed and dated checklists.

Assessing and responding to patient risk

- The community dental service provided a range of specialised dental services to treat people with complex or special needs and vulnerable people who met their acceptance criteria. These included people who required inhaled or intravenous sedation or general anaesthesia. We saw evidence that staff had received training to provide inhalational sedation.
- Inhaled sedation was available at all the centres and could be titrated, whereby the mix of nitrous oxide and oxygen could be altered. This meant that sedation could be carefully measured to ensure a safe amount of sedation was administered according to the patient's individual needs.
- Intravenous sedation was administered at all the centres, although they were undertaken during dedicated lists and not on an ad hoc basis. This ensured the patient had been thoroughly risk assessed, informed consent obtained and the nurse assisting the dentist was thoroughly trained and competent to assist with these procedures.
- The minimum amount of sedation, whether IV or inhaled, was given, to ensure the patient was relaxed and co-operative.
- Specialised treatment, for example general anaesthesia, was undertaken at dedicated centres with the appropriate trained staff and support systems to ensure patient safety.
- The service used an assessment tool called 'The Case Mix Model'. This is a tool designed to measure patient complexity by using a system of identifiable criteria applied to a weighted scoring system. The model

identifies the various challenges patient complexity can present for dental services (such as difficulties in communication or cooperation). These challenges may result in the need for a greater length of time or additional staff to provide care for a particular patient, in comparison with an average member of the population.

- Staff we spoke with explained that each patient attended a pre-assessment visit with one of the dentists to understand their medical history and identify any individual risks prior to deciding the appropriate course of treatment.
- Patients who required general anaesthetic (GA), although they were assessed at the community dental clinics, were treated at either Leighton or Macclesfield Hospital. Any patients who were deemed to be at a higher risk because of existing medical conditions were formally assessed by an anaesthetist at the hospital prior to general anaesthesia. Often the patient would require a pre-procedure 'work up', which may include blood tests, chest x-rays or electrocardiograph (ECG) and relevant treatment to ensure that the patient was as fit as they could be prior to the procedure. There was a full theatre team in attendance when GA was administered. This included an anaesthetist. Dentists did not administer GA.

Staffing levels and caseload

- The community dental service provided a range of specialised dental services to treat people with complex or special needs and vulnerable people who met their acceptance criteria, for example people with dental phobias. The appointment times were longer than in a traditional dental practice to allow the staff to respond to the patent's particular needs.
- Staffing levels were adequate for the type of work that was being undertaken. Agency staff were rarely used. Staff worked flexibly between the units to cover for leave and staff illness.

Managing anticipated risks

- During the provision of treatment and the decontamination of instruments, staff were observed to use and wear the appropriate personal protective equipment, such as aprons, gloves and goggles. Patients were also suitably protected and provided with bibs and safety glasses to wear during treatment.
- Emergency equipment was available at each site visited and included oxygen, emergency medicines and defibrillators.
- There were systems in place for the segregation and correct disposal of waste materials such as x-ray solutions, amalgam and sharps. Sharps containers for the safe disposal of used needles were available in each clinical area; these were dated and were not overfilled. Notices were displayed in clinical areas explaining the actions staff should take in the event of an injury from a needle.
- Information leaflets and notices were displayed to remind people of the importance of notifying their dentist if they were taking oral anticoagulants and to inform them of the associated risks. Where people were treated in their homes, the dentist ensured that people had written contact details that told them how to obtain urgent help via the out-of-hours service.
- The service employed a radiation protection adviser and each site had a dedicated radiation protection supervisor.

Good

Are Community Dental Services effective?

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

Summary

The community dental service positively engaged and worked in partnership with other services – for example referring dentists, healthcare professionals and local hospitals – to meet the needs of patients in a coordinated and timely way.

All new staff received a comprehensive induction. This meant that they were given support and guidance to ensure that they were able to undertake their role safely and effectively.

The service was effective at monitoring, managing and improving outcomes for patients. Examples of guidance produced to date included conscious sedation and a comprehensive oral health promotion for people with special needs.

We saw that a number of audits had taken place and the results had been used to improve the service.

Detailed findings

Evidence-based care and treatment

- Staff had undertaken an audit to monitor performance. The audit looked at the referrals received to identify whether the service was being used appropriately. Care was given according to available evidence of best practice, for example from the National Institute for Health and Care Excellence (NICE), British Dental Association (BDA) and General Dental Council (GDC).

Pain relief

- Local or inhaled pain relief was administered according to the treatment and the setting in which the treatment took place. The dentists gave verbal advice following treatment. Advice leaflets were available at all the centres; these gave advice on pain relief for when the patient returned home. One patient told us: "They always make sure I have the least pain possible. They know I can't lie down, they know I need a pillow for my neck. It's just a terrific service I get here."

Patient outcomes performance

- A number of audits had taken place to monitor the effectiveness of treatment, for example an audit of minor surgery outcomes. This showed that excellent results had been achieved in 97% of surgeries undertaken. There was an action plan in place to continue to audit these outcomes. Further audits, for example of record keeping, had taken place.
- Patients we spoke with were extremely satisfied with the care and treatment they received. One told us: "It's too good to be true." A relative told us: "They just have more time for my son. Everyone here is so kind and understanding of his particular needs."
- The dentist and staff at the Eagle Bridge Centre explained that they participated in epidemiology studies planned by the Dental Public Health Intelligence Programme to improve patient outcomes. We saw that staff had been supported and trained to use the system and to participate in the national programme.
- Staff undertook regular audits of clinical records and consent processes. The results of these were reported at monthly staff meetings to ensure shared learning and to agree actions to improve standards of record keeping. Other audits had included the use, dose and efficacy of local anaesthesia.

Competent staff

- All the clinical staff were registered with the GDC. The GDC is an organisation that regulates dental professionals in the UK. Several of the dentists were also registered on the specialist list. This meant that they had met certain requirements and had been given the right by the GDC to use the title 'specialist'. There were specialists in areas including oral surgery and children's dentistry. Staff throughout the service reported that, although they worked mainly at their 'base' site, they were supported and encouraged to work across the dental network to ensure business continuity and to share skills.
- We saw evidence, certificates and staff descriptions of clinical staff participating in continuing professional development in line with GDC requirements.

Good

Are Community Dental Services effective?

- We saw that, depending on which site was involved, between 85% and 98% of staff had completed their mandatory training. Some described study days and courses that the trust had sponsored them to complete. All staff reported to us that they were satisfied with internal and external training opportunities. The staff we spoke with said that they had regular appraisals that gave them the opportunity to discuss their performance and career aspirations with their manager. Staff reported to us that they had the opportunity to have one-to-one meetings with their manager. However, these were not formalised, although all the staff we spoke with said that they felt valued and supported.

Use of equipment and facilities

- All the centres had modern treatment rooms, most with integrated digital x-ray facilities. This meant that patients could stay in the dentist's chair to have any x-rays taken. The centre at Victoria Infirmary had an old analogue x-ray machine. However, this was surveyed in line with national guidelines by the designated radiation protection adviser. Each centre had an orthopantogram (OPG), a machine that takes panoramic x-rays of the mouth, although the OPG at Weston was not functioning. This was on the trust's risk register. Patients were sent to a nearby centre if they required an OPG.
- We saw records relating to the maintenance of various items of equipment. Much of this routine maintenance was carried out by the trust. This meant that equipment was checked regularly and safe to use.
- All the centres we visited had adequate waiting facilities with wheelchair access and easily accessible toilets.

Multidisciplinary working and coordination of care pathways

- Staff worked in partnership with other primary and specialised dental services to ensure an effective and patient-focused service. For example, we saw evidence of referrals to other professionals such as facial/maxillary and oral surgeons. Staff we spoke with were able to explain the procedures for screening and making referrals to other specialists outside the community dental service.
- Furthermore, there was coordination with medical services outside the dental service so that patients scheduled for treatment under GA could have two or more procedures carried out at the same time to minimise the number of GAs a patient received.

Good

Are Community Dental Services caring?

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

Summary

Patients and their relatives told us that they were involved in their care where appropriate and were given time to ask questions about any aspect of their treatment. The use of individualised clinical notes and patient treatment plans enabled patients and their relative to understand and participate in their treatment wherever possible.

Staff told us about the different ways in which they responded to and cared for the diverse and complex needs of patients using the community dental service. For example, staff described how they ensured that they had appropriate staffing levels for the needs of their patients to allow enough time when patients were attending appointments. One member of staff told us: "We give patients as much time as they need. It means that compared to a high street dentist we have longer appointments, but it means we can take time to give everyone the care they need."

Patients we spoke with felt that their particular needs and concerns were understood and respected by staff. Staff we spoke with were very proud of and committed to providing a specialised dental service for patients with complex or special needs and for vulnerable people who found it difficult to access general dental services.

Detailed findings

Compassionate care

- Patients and their relatives told us that staff were patient and understanding. People spoke positively about the care and treatment received. One relative said: "They are so wonderful. I've been bringing my son here for years; they really know him now and understand how to talk to him so that he doesn't get distressed and go off on one." In addition, the reception staff knew all the patients well, took time with people booking appointments, offered different options to patients, and checked that people understood the appointment system.
- Staff we spoke with said: ''The best thing about this job is the patients; they are all so interesting. We all like that we have time for them. At a traditional high street dentist they wouldn't be able to cope with some of our patients, as they have extra needs that we need to consider and give time for."
- All the patients we spoke with during our inspection made very positive comments about the service. One told us: "It's great here. I have a condition which most dentists I have been to had never heard of, never mind understood. I would have lost all my teeth by now if it hadn't been for all them here."
- During our inspection, we heard and observed good interactions between staff and patients. For example, we saw a dental nurse chatting to a child about hidden sugar in cereals.

Dignity and respect

- Staff told us that they had completed equality and diversity training and confirmed their awareness of the trust's values and the unique needs of the patients they cared for**.** We observed that patients were treated with respect and dignity during their time at the clinics.
- The staff were familiar with patients' anxieties and took time to reassure and relax the patient without needing to use medication. For example, we saw that acclimatisation appointments were given to familiarise patients with the dental surgery setting. A member of staff said: "What we do is bring them in and then first time they just sit in the chair and we let them play with the up and down controls. If they're okay with that we would let them use the air and suction on their hand so that they knew what noises it made. It isn't until people are completely comfortable that we start treatment. We'd usually start with something gentle like a teeth cleaning." We saw that appointments were made and notes put in the appointment instructions that said, for example: "Promised that he could play with the suction and air when his treatment finished." This meant that patients were treated according to their individual needs.
- People were greeted in a friendly and courteous manner and reception staff were discreet to ensure patient confidentiality when booking appointments for patients in the reception area or by telephone. During treatment, doors were kept closed to ensure privacy.

Good

Are Community Dental Services caring?

Patient understanding and involvement

- Guidance was available for staff in relation to consent. We reviewed the consent policy and the Mental Capacity Act policy for the service. The dental service provided care, treatment and support to a large number of vulnerable patients who lacked capacity. A consent policy had been developed by the trust to provide clarity for practitioners working within the service.
- The clinical records we saw provided evidence that the capacity of patients had been taken into consideration when assessing new patients and obtaining consent or agreement for treatment.
- Staff confirmed that they were aware of the need to obtain consent and were clear about what action should be taken when an adult patient did not have the capacity to give or withhold consent in order to justify 'best interest' decision-making processes. We reviewed six patients' notes and saw evidence of discussions that had taken place regarding treatment plans.
- Patients and their representatives confirmed that they had given consent to treatment and that the treatment options and plan had been discussed with them prior to giving consent. We saw three signed consent forms that had been completed thoroughly; these included a list of the risks and benefits of the procedure.

Emotional support

- People were consulted at each stage of treatment to ensure that staff had their permission to proceed. People were also given reassurance before continuing. For example, one person we spoke with had a phobia of dental treatment and told us: "I had some terrible experiences at the dentist. I didn't go for 30 years as I was so scared. Since I moved here two years ago, they've been brilliant. I am never made to feel like I am stupid or a nuisance because I'm scared. They explain everything and let me have a breather when I need to."
- A child showed us that they had received stickers after treatment as a reward.

Promotion of self-care

- The service did not employ hygienists. However, we saw in the records that the dentist gave oral hygiene advice to patients at each visit.
- The service employed four oral health advisers, who between them worked 1.8 WTE (whole-time equivalent) hours. As part of their role, they provided an oral health service both in the clinics and in the community They advised and trained carers, care homes and schools and had been involved in a nursery project in a children's centre to increase oral health awareness. Furthermore, they ran sessions for carers on maintaining good oral health in people with special needs. At the Eagle Bridge Centre, there was a resource room with 10 model heads so that the oral health advisers could run practical sessions on oral hygiene. The advisers could screw different types of teeth into the heads so that they could demonstrate how to clean the teeth of people who may not have had typical dentition, or when access to all their teeth was difficult. While we were there, the oral hygiene adviser showed us how different types of toothbrush (for example, two-way, suction or curly) assisted in cleaning people's teeth. Although this resource was available, the oral hygiene adviser emphasised that most of their work took place in the community.
- Some of the oral health advisers' work was based around a toolkit published by Public Health England and updated in June 2014, entitled 'Delivering Better Oral Health'. This was in line with best practice guidance.
- The service was also taking part in a national project to check the condition of teeth in children aged five years. NHS England was coordinating this and it was hoped that it would eventually contribute to improving oral health in children by demonstrating that, for example, reducing sugary food and drink and fluoridating water supplies improves oral health in children and in later life.

Good

Are Community Dental Services responsive to people's needs?

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

Summary

Staff understood the particular needs of their patients and 'went the extra mile' in order to provide a service that met their patients' complex needs. Reasonable adjustments were made according to the individual needs of patients. There was collaborative working between the service and other healthcare services, for example local dental surgeries, social workers and care homes, to ensure that patients' needs were met and their outcomes optimised with regards to dental health.

Obtaining feedback from patients was actively promoted and we saw evidence that information was used to improve the service.

We found that the dental service understood the needs of its population and made adjustments to ensure that its patients were treated as individuals, according to their needs.

Detailed findings

Service planning and delivery to meet the needs of different people

- People were referred to the community dental service if they were assessed as having complex or special needs, including learning difficulties, and if treatment with a general dental practice was not possible. The service also met the needs of children under 16 years of age with behavioural or management problems that made them unsuitable for treatment within general dental services.
- We saw that the centres were able to treat people who were wheelchair-bound by giving them extra time and adjusting the way in which they worked; for example, staff used cushions to support their head, or positioned them in a way that was comfortable for them, so that they could receive dental treatment.
- Appointments were timed to last longer than is usual at dental surgeries to allow people with more complex needs the time they needed.
- Staff reported that most patients were seen within six to eight weeks from referral.
- Staff we spoke with reported that in some cases patients were referred to the community dental service for short-term specialised treatment. On completion of the treatment, the patient was discharged to the patient's own dentist so that ongoing treatment could be resumed by the referring dentist.
- Referral systems were in place should the community dental service decide to refer a patient to other external services, such as orthodontic or maxillofacial specialists.
- The service worked collaboratively with other services such as general dental practitioners, social workers and hospital teams: for example, for patients whose medical condition necessitated dental care being undertaken in a hospital setting. Because the dentists and surgeons worked collaboratively, patients received care in an environment that could safely meet their needs.

Access to the right care at the right time

- We observed that staff made every effort to accommodate people's needs when planning appointments. The service had arrangements to accommodate patients who needed to be seen urgently. There were three dental access centres, in Macclesfield, Nantwich and Northwich; all of them included an out-of-hours service that was open for part of every day, including on bank holidays and at weekends. The dental access centres provided urgent dental treatment to those patients who had been unable to obtain treatment swiftly in a general dental setting.
- The service could be accessed by self-referral or by referral by other health professionals. We saw that information was displayed and provided on the opening hours of the practice and how to access the out-of-hours service.

Discharge, referral and transition arrangements

- Staff explained that, on completion of treatment, patients were discharged into the care of general dentistry unless the severity or complexity of their condition required their care to continue within the specialised service. Where patients continued to meet the acceptance criteria for the specialised service, they were advised that recall appointments would be offered at appropriate intervals in accordance with NICE guidelines.

Good

Are Community Dental Services responsive to people's needs?

Complaints handling and learning from feedback

- Complaints were dealt with in line with the trust's policy. The trust had received 180 complaints since November 2013. However, only one related to dental services and it was dealt with appropriately. The receptionist and dental nurses told us that they sometimes received low-level verbal complaints, for example about waiting times. They told us that they talked to the patient or their carer and did their best to rectify the problem immediately. The receptionists confirmed that they had received training in resolution; however, this had been some time ago. We saw that patients' letters, including those from children, about the care they had received were displayed in the reception areas and the comments were positive.
- Staff said: "We try to make the person feel important and that their concern will be taken seriously." They told us that they would notify their line manager and document what the patient had reported to them.
- We saw minutes of a staff meeting where there had been a discussion of and subsequent learning from a complaint.

Good

Are Community Dental Services well-led?

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

Summary

There was clear leadership and a quality framework used to ensure the delivery of safe care and the effective use of resources. There was commitment from staff to obtain and learn from feedback from patients, including the use of audits to improve the quality of the service.

We saw evidence of improvement initiatives and that the quality of the service was monitored.

There was a clear leadership and management structure, and the areas of responsibility for each clinical lead were unambiguous.

There was a commitment from the managers to learn from feedback, complaints and incidents.

All the staff we spoke with were passionate about working within the service and about providing good-quality, individual care for patients. We saw evidence of service improvement initiatives and some monitoring of the quality of the service: for example, audits of infection control, the use of local anaesthetics and x-rays.

Detailed findings

Vision and strategy for this service

- Staff were able to describe the aim of the service, which is to complement general dental practice by providing specialised services for patients with complex or special needs, vulnerable people and those who cannot obtain general dental services because of those needs. The senior staff wanted to continue to develop the service and not to be seen as the 'poor relation' of dental services. They were also keen to be innovators in dentistry and to drive improvements in the health of their patients, so that they were leaders and not followers with regards to innovative care for their client group.

Governance, risk management and quality measurement

- Staff we spoke with were proud of the service and were committed to ensuring that patients received a compassionate and high quality of care. During our inspection, we observed that this passion and commitment translated into the actual delivery of care. Patients we spoke with were keen to tell us how impressed they were by the service provided; in particular, they mentioned the understanding and patience of staff to ensure that their needs were met.
- We saw a number of different audits developed by the dental team but it was unclear how this information fed into the trust's overall quality and risk assurance framework.
- There were few incidents or complaints within the dental service. We saw that there was a governance structure which included sub-committees such as infection control, clinical audit and effectiveness. Any issues, such as incidents or infections relating to dental services, were reported into the trust's quality and risk assurance framework to facilitate the overall identification of trends and to ensure that lessons were learned.
- Staff were passionate about working within the service and providing good-quality care for patients. We saw evidence of service improvement initiatives and regular monitoring of the quality of the service. For example, dentists and dental nurses worked across the service to ensure consistency.

Leadership of this service

- Staff generally spoke well of senior management within the dental service. Staff said that they were supportive and responsive. They described their managers as being approachable. There were meetings held bi-monthly within the dental service; the surgeries were closed for the afternoon so that all staff could attend. These were followed up with written minutes, which were available for staff to read.

Culture within this service

- Staff at all levels told us how proud they were to work within the dental service and proud of the work they did. Staff told us that they had opportunities to meet with their managers and other team members, who were approachable, supportive and visible.

Good

Are Community Dental Services well-led?

Innovation, improvement and sustainability

- The community dental service carries out epidemiological surveys using national standards and criteria set by the Department of Health to provide information to inform the planning of dental services regionally and nationally.
- Screening of local populations was undertaken where there was evidence that needs were unmet in order to improve oral health and find the most effective way of meeting those needs. We saw evidence of oral health promotion activities including in schools and children's centres.
- Staff described their staff meetings and study days when, for example, a wheelchair user had been invited to speak to them. The staff we spoke with found these sessions invaluable.
- The community dental service provided a service for those who could not access other dentists and those who were not registered and needed emergency care. The clinical lead told us that their strategy was to grow their specialist services to meet the needs of the local community.