Care Quality Commission

Sheffield Teaching Hospitals NHS Foundation Trust

RHQ

Community dental services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RHQ16	Firth Park Clinic	NA	S5 6NU
RHQ19	Heeley Clinic	NA	S80 0ZS
RHQX4	Limbrick Clinic	NA	S6 2PE
RHQX5	Jordanthorpe Clinic	NA	S8 8DJ
RHQDM	Manor Clinic	NA	S12 2ST
RHQDW	Wheata Place Clinic	NA	S5 9JH
RHQX2	Norfolk Park Clinic	NOT INSPECTED	
RHQX1	Talbot/Oakes Park Clinic	NOT INSPECTED	

This report describes our judgement of the quality of care provided within this core service by Sheffield Teaching Hospitals NHS Foundation 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 Sheffield Teaching Hospitals NHS Foundation Trust and these are brought together to inform our overall judgement of Sheffield Teaching Hospitals NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Outstanding ☆
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

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Summary of findings

Overall summary

We rated the community dental services at this trust as outstanding. This was because:

- Staff protected patients from abuse and avoidable harm. A specialist dentist working in the service had contributed to the development of theresource website ‘child protection and the dental team’, initially funded by the Department of Health and now hosted by the British Dental Association. This resource is used nationally by general dental practice teams for the effective management of safeguarding children in dental practice. Systems for identifying, investigating and learning from patient safety incidents were in place. Infection control procedures were in place. The environment and equipment were clean and well maintained and medicines and emergency equipment was available at each site we visited to deal with medical emergencies. However, due to the age and design of the Manor clinic the delivery of optimal care to patients who were confined to a wheelchair was difficult.
- The dental services were effective and focused on patients’ and their oral health care. We saw several examples of innovative care approaches including the provision of care to the most vulnerable members of society. Those vulnerable members included Sheffield’s homeless community who were treated through the The service could meet patients’ needs because of the flexible attitude of all service members. In collaboration with commissioners of dental services and dental public health consultants, Sheffield community dental service developed a domiciliary service called Residential Oral Care Sheffield (ROCS). Senior dentists and the oral health promotion team in the service work in partnership with local general dental practitioners to deliver effective dental care to 90 care homes in Sheffield.
- Patients, relatives and carers said they had positive experiences of care within the service. We saw good examples of staff providing compassionate and effective care. We also saw effective interactions taking place between individual staff members. We found staff to be hard working, caring and committed to the care and treatment they provided. Staff spoke with passion about their work and conveyed their dedication to what they did.
- Staff responded to patients’ needs at each clinic we visited. The service kept treatment delays for routine dental treatment within reasonable limits through effective resource management. Effective multidisciplinary team working ensured the service provided patients with care that met their needs and at the right time. We saw specialist dental teams delivering dental care to mental health services, the homeless of Sheffield, the spinal injuries unit and special schools.
- The community dental service was well led. Organisational, governance and risk management structures were in place. The service’s operational management team was visible and the working culture appeared open and transparent. Staff were aware of ‘PROUD’ and the organisation’s vision and way forward and they said they felt well supported and that they could raise any concerns.
- The Sheffield community dental service had achieved national profile status in community dentistry through a number of innovative projects. The clinical lead was instrumental in developing a ‘case mix’ tool kit that is used to describe the complexity of the patients treated in the community dental services. Commissioners of dental services when commissioning community dental services use this tool kit as a national benchmark. Commissioners also use the tool kit as a key performance indicator when judging the effectiveness of a community dental service.

Summary of findings

Background to the service

Sheffield NHS Foundation Trust provides dental services in six community dental clinics spread across Sheffield. The service also provides dental care at three special schools and the spinal injuries unit. A dental service is also provided at the 'Cathedral Archer Project,' a voluntary organisation that focuses on the needs of homeless patients. The clinics, special schools and the other locations serve patients of all ages who need specialised dental care approaches that are not available in general dental practices. The service includes oral health care and dental treatment provision for patients with impairments, disabilities and/or complex medical conditions. This provision extends to patients with physical, sensory, intellectual, mental, medical, emotional or social impairments or disabilities including those who are housebound and homeless.

The service offers conscious sedation and acupuncture in selected clinics when treatment under local anaesthetic alone is not feasible. A service for patients requiring general anaesthesia (GA), for example, the very young, the extremely nervous, patients with special needs and patients who need multiple extractions was provide at the Royal Hallamshire Hospital.

During our inspection we visited six community dental service locations:

- Firth Park Clinic
- Heeley Clinic
- Limbrick Clinic
- Manor Clinic
- Jordanthorpe Clinic
- Wheata Place

We also accompanied the Manor dental services team on several domiciliary visits. The community dental service also supports the undergraduate teaching programme of the Charles Clifford Dental Hospital. Staff from Firth Park and Wheata Place clinics supervise dental students carrying out dental treatment on members of the public. Specialist dentists working in the service also provide postgraduate teaching and training of dentists. The service has an oral health promotion team leading on prevention services and a dental nurse led team who focus on the management of patients with dental phobia. The service also provides dental care at mental health secure units one each for adults and children.

Our inspection team

Our inspection team was led by:

Chair: Professor Stephen Powis, Medical Director

Head of Hospital Inspections: Amanda Stanford, Head of Inspection

The team included CQC inspectors and a variety of specialists: including a dental nurse and dental specialists.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection programme

Summary of findings

How we carried out this inspection

We inspected this service in December 2015 as part of the comprehensive inspection programme.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit from 8 to 11 December 2015.

What people who use the provider say

During our inspection, we spoke with patients and their carers at Jordanthorpe clinic to gain an understanding of their experiences of care. They said they were very happy with the care and support provided by the staff. Family and Friends Test analysis for October 2015 that showed patients were extremely likely or likely to recommend the service to family or friends.

Good practice

- A collaboration between the Sheffield Community Dental Services, NHS commissioners, Dental Public Health consultants and local general dental practitioners led to the development of the Residential Oral Care Sheffield service for residents living in care homes. This collaboration was cited as good practice by the British Society for Disability and Oral Health. This service now covers 80 out of the 88 residential care homes who participate in the scheme in the city of Sheffield.
- The clinical lead was instrumental in developing a national benchmarking tool used by other community dental services and NHS dental commissioners for describing the complexity of patients treated by community dental services. An evaluation of the outcomes of the pilot project was delivered at the National Association for Dentistry in Health Authorities and Trusts in 2014.
- Collaboration between the Clinical Lead of Sheffield Community Dental Services and the Head of Psychotherapy Services within Sheffield Health and Social Care Foundation Trust developed a dental nurse led Pain and Anxiety Service. This led to a reduction in the numbers of patients needing intra-venous sedation for dental treatment and the overall waiting times for intra-venous sedation.
- Sheffield Community Dental Service provided a service for the Sheffield homeless under the auspices of the 'Archer Project at the Cathedral'.
- Sheffield Community Dental Service had developed a communication tool known locally as 'the widget sheets' enabling children with autistic spectrum disorders and other communication difficulties to accept dental treatment. An evaluation of this audit tool was published in the peer reviewed international scientific publication 'Journal for Disability and Oral Health in 2014.
- The development of a number of nationally recognised clinical benchmarking tools by Sheffield Community Dental Service was a result of exceptional leadership provided by the current Clinical Lead of the Service.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust should review the access for patients requiring dental treatment at Manor Clinic who use wheelchairs

Care Quality Commission

Sheffield Teaching Hospitals NHS Foundation Trust

Community dental services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good. This was because:

- The dental service used the trust electronic incident reporting system to identify, investigate and learning from patient safety incidents.
- Staffing levels were safe in the clinics with a good staff skill mix across the whole service.
- Radiography was maintained at each of the locations we visited by specialised technicians from the Trust or external companies.
- Infection prevention control practices and equipment used to process contaminated instruments and equipment at Jordanthorpe dental clinic was maintained appropriately in accordance with national guidelines.
- Dental service staff received adult and children safeguarding training and were confident in their knowledge of how to escalate concerns.
- Staff informed other professionals when children missed clinic appointments in order to identify potential risks in relation to safeguarding concerns.
- We found that dentists carried out conscious sedation in accordance with the new guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in April 2015.

However, we also found that:

- Due to the age and design of the Manor clinic the delivery of optimal care to patients who were confined to a wheelchair was difficult.

Detailed findings

Incident reporting, learning and improvement

- There had been no never events in the dental service in 2015. Never events are serious, largely preventable patient safety incidents that should not occur if available preventative measures are implemented. An example of a never event in dentistry is a wrong tooth extraction. We saw that the dental service used a surgical safety checklist before a surgical intervention was carried out under local and general anaesthesia. Under this system, the team checked that before the procedure was carried out; the patients' identity was correct, along with their medical details.
- The dental service reported incidents using the trust electronic reporting system. Staff we spoke with

demonstrated to us how the system worked. The system appeared easy to use and staff reported that the system would always acknowledge the receipt of the particular incident reported. The service manager, team leaders or clinical lead would always follow up issues resulting from reported incidents.

- We saw evidence of a rolling programme of audits to monitor safety performance including safe site surgery compliance, infection control, radiographs, conscious sedation and patient records.
- Staff meeting minutes showed that incidents were discussed to facilitate shared learning. There were also standing agenda items relating to equipment, health and safety alerts, risk management issues and clinical audit.

Safeguarding

- The clinical lead had appointed a specialist dentist in the service as the safeguarding lead. The specialist dentist working in the service had contributed to the development of the resource website 'child protection and the dental team', initially funded by the Department of Health and now hosted by the British Dental Association.This resource is used nationally by general dental practice teams for the effective management of safeguarding children in dental practice.
- Dental staff we spoke with were aware of the safeguarding policy and had received training appropriate to their clinical grade. The level of training received by staff was either Level 2 or 3. Level 3 training was provided for senior dentists in the service for whom child protection is a regular feature of their work,
- The mandatory training records we saw demonstrated that 100% of staff working within the service had received safeguarding training.
- The staff we spoke to were knowledgeable about safeguarding issues in relation to the community they served.
- All of the dentists we spoke to were aware of how safeguarding concerns could affect the delivery of dental care. This included children who presented with high levels of dental decay that could indicate that a child could be suffering from neglect and patients who did not attend for treatment.
- We saw that the service had developed an information sharing system where they would alert and share information with other professionals such as social workers, health visitors, school nurses and learning disability teams.

Medicines

- We found that there was a recording system for the prescribing and recording of medicines used in the provision of conscious sedation; this included the reversal agent for the sedative medicine. We saw that there was a robust written system of stock control and storage for the medicines used in intravenous sedation. We found that the recording of dose and amount of medicines prescribed along with the batch number and expiry date was always recorded in the controlled drugs book.
- We saw that a comprehensive recording system was used for the prescribing and recording of medicines. Local anaesthetics, antibiotics and high concentrated fluoride toothpaste when prescribed were clinically justified. Clinical records we saw showed the details of the prescription were recorded in full.
- We found medicines for emergency use were available at all times, in date and stored correctly.
- We saw that dental nurses used a checklist for monitoring the expiry dates of the emergency medicines. We saw that the responsible dental nurse at each location we visited signed this.

Environment and equipment

- We observed that dental equipment was clean and well maintained.
- We found that at each site we visited equipment was present for dealing with medical emergencies this included an Automated External Defibrillator, emergency medicines and oxygen. This was in line with the Resuscitation UK and British National Formulary (BNF) guidelines.
- At each site we visited, we saw a well maintained radiation protection file. This contained all the necessary documentation pertaining to the maintenance of the X-ray equipment. The file contained the critical examination packs for each X-ray set along with the regular maintenance logs in accordance with a

copy of the local rules. A radiation protection file was kept in each dental treatment room at each location. These measures were in accordance with national regulations pertaining to ionising radiation.

- The dental service ensured that all X-ray sets were serviced and calibrated on an annual basis. We saw that the service records for each X-ray set used across the service indicated that they were safe for use.
- Dental X-rays when prescribed were justified, reported on and quality assured every time. We saw dental records that confirmed that this was the case. This ensured that the service was acting in accordance with national radiological guidelines and protected staff and patients from receiving unnecessary exposure to radiation.
- Staff ensured that equipment checks had been carried out before a procedure commenced. Following the procedure, staff checked that all planned procedures had been carried out, that the sharps and single use items had been disposed of appropriately and that the surgical procedure count was correct. This included the swabs and throat packs that remained with the patient.
- Due to the age and design of the Manor clinic the delivery of optimal care to patients who were confined to a wheelchair was difficult. The clinical lead explained that to provide this optimal care a 'wheel chair' tipper device was required. The doorways, corridors and size of the dental treatment room within the dental suite prevented the use of such a device.

Quality of records

- The individual patient records were a mix of computerised and paper records.
- Clinical records were kept securely so that confidential information was properly protected. Information such as written medical histories, referral letters and dental radiographs were collated in individual patient files and archived in locked and secured cabinets not accessible to the public in accordance with data protection requirements. Computerised records were password protected.
- The records we observed were well-maintained by each dentist and provided comprehensive information on the individual needs of patients such as; oral examinations; medical history; consent and agreement for treatment; treatment plans and estimates and treatment records.
- Clinical records we viewed were clear, concise and accurate and provided a detailed account of the treatment patients received. Dental staff recorded patient safety and safeguarding alerts. For example allergies and reactions to medication such as antibiotics.

Cleanliness, infection control and hygiene

- The service used a separate provider for central decontamination of dental instruments and equipment for all but one of its locations.
- At the Jordanthorpe clinic where local decontamination of dental instruments and equipment was carried out the service was meeting best practice HTM 01 05 (guidelines for decontamination and infection control in primary dental care) for infection control.
- Staff at Jordanthorpe showed us and demonstrated the arrangements for infection control and decontamination procedures. They were able to demonstrate and explain in detail the procedures for the cleaning of dental equipment. Staff described the process for the transfer and processing of dirty instruments through designated on-site decontamination rooms. We saw safe storage of clean instruments and were assured that equipment was used within the timescales stipulated in HTM 01 05. We observed that the dental nurses at Jordanthorpe clinic maintained the daily, weekly and quarterly test sheets for the equipment used in decontamination of dental equipment. This included autoclaves and the washer disinfector. The dental nurses also kept records of the maintenance schedules for this equipment.
- We observed good infection prevention and control practices across the service. Hand washing facilities and alcohol hand gel were available throughout the clinic areas.

Good

Are services safe?

- We observed staff following hand hygiene and 'bare below the elbow' guidance. Staff wore personal protective equipment (PPE), such as gloves and aprons, whilst delivering care and treatment. We observed appropriate disposal of PPE.
- We saw that there were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps. Safer sharps use which was in accordance with the EU Directive for the safer use of sharps.
- We found that cleaning schedules were in place and displayed for each individual treatment room. The responsible dental nurse at each clinic had signed off each schedule.
- Clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment were in place at each location.
- We saw that the dental nurses carried out infection prevention and control audits at regular intervals in 2015. The results of the audits we saw showed exceedingly high levels of compliance in infection control across the whole of the end-to-end decontamination process. The Infection Prevention Society Audits were carried out in the service during December and June each year in accordance with HTM 01 05 guidelines. Audits revealed only very minor deficiencies and these had been addressed by the service in the action plans we saw.

Mandatory training

- Staff across the service told us there was good access to mandatory training study days.
- Mandatory training for staff included infection prevention and control, safeguarding for vulnerable adults and children, information governance and the management of emergencies in the dental chair.
- The central log for mandatory training we saw confirmed that all staff working in the clinics across the service either had attended the required mandatory training or were booked to do so. The service managers were diligent in their management of staff in relation to mandatory training and ensured that staff achieved the trust targets.

Assessing and responding to patient risk

- At every site we visited, there was a range of equipment to enable staff to respond to a medical emergency. This included an Automated External Defibrillator, emergency medicines and oxygen. The emergency medicines were all in date and stored securely, with emergency oxygen, in a central location known to all staff. This was in line with the Resuscitation UK and British National Formulary (BNF) guidelines.
- Throughout our inspection visits, we looked at a sample of 2-3 dental treatment records at each location. We found that dental staff always recorded patient safety and safeguarding alerts. For example, medical histories were always taken by dentists and updated when patients attended for dental treatment. These medical histories included any allergies and reactions to medication such as antibiotics.
- Four dentists we spoke with felt that they had adequate time to carry out clinical care of patients. They had sufficient clinical freedom to adjust time slots to take into account the complexities of the patient's medical, physical, psychological and social needs.
- We visited the Limbrick site where dental staff treat patients with mental health issues. During our visit, we saw that the staff had carried out ongoing risk assessments for individual patients that were suffering from mental health issues that could present a risk to staff. To mitigate the risks to staff of potentially violent patients the surgery layout had three exit doors this design feature prevented any dental staff from being trapped inside a dental treatment room with a potentially violent patient. Staff at the clinic had received appropriate training in dealing with such patients.
- The staff also ensured that patients and carers received appropriate post-operative instructions following dental surgery. This minimised the risk of the patient suffering from post operative complications such as post extraction haemorrhage and infections.

Staffing levels and caseload

- The staffing levels at each location we visited were appropriate. Each dentist and dental therapist hygienist was supported by a suitably trained and experienced dental nurse. We found that teams worked well together.

Good

Are services safe?

- The special care element of the service worked closely with the Charles Clifford Dental Hospital in running an apprenticeship programme for dental nurses.
- The service also provided domiciliary care across the whole of the city of Sheffield.
- The appointment diaries at each location we visited showed that appropriate appointment slots were allocated for both patient assessment and treatment sessions.

Managing anticipated risks

- We found that dentists carried out conscious sedation in accordance with the new faculty guidelines published by the Royal College of Surgeons and Royal College of Anaesthetists in April 2015.
- We found that the community dental service had put into place robust governance systems to underpin the provision of conscious sedation. The systems and processes we observed were in accordance with the new faculty guidelines.
- The governance systems we saw included policies and protocols for pre and post sedation treatment checks, emergency equipment requirements and medicines management. Dentists and dental nurses carried out other checks for reasons of safety. These included sedation equipment checks, personnel present, patient checks including consent, discharge and post-operative instructions.
- We found that patients were appropriately assessed for sedation by staff. We saw dental treatment records that showed all patients undergoing sedation had important checks made by dentists prior to sedation. Dentists carried out a detailed medical history and an assessment of health using the American Society of Anaesthesiologists classification system in accordance with current guidelines.
- The clinical records we saw demonstrated that during the sedation procedure important checks were recorded at regular intervals by staff. We saw that this included pulse, blood pressure, breathing rates and the oxygen saturation of the blood. Dental staff used a pulse oximeter to measure the patient's heart rate and oxygen saturation of the blood and blood pressure.
- Two appropriately trained nurses supported the dentists carrying out sedation on each occasion. This was also recorded in the dental care records with details of their names. The measures in place ensured that patients were being treated safely and in line with current standards of clinical practise.
- All staff undertook yearly training in cardiopulmonary resuscitation appropriate to the clinical grade of the member staff. For example, staff involved in providing intravenous sedation, relative analgesia sedation or general anaesthetic services undertook training in Intermediate Life Support Techniques. This was in accordance with the new guidelines recently published by the Royal College of Surgeons and Royal College of Anaesthetists in April 2015.
- Dentists carried out important checks before patients received conscious sedation. We saw the clinical records of two patients. The records showed that the dentist had checked the medical history, ability to breathe through the nose, time of last meal and the availability of an escort.
- The service had a named Radiation Protection Adviser and Radiation Protection Supervisors ensuring that the service complied with legal obligations under IRR 99 and IRMER 2000 radiation regulations. The ionising regulations required periodic examination and testing of all radiation equipment, a radiological risk assessment, contingency plans, staff training and a quality assurance programme. The named Radiation Protection Supervisor at each location ensured that compliance with Ionising Radiation Regulations 99 and IRMER 2000 regulations was maintained.
- At each location we visited, a well-maintained radiation protection file was available. Each treatment room contained all the necessary documentation pertaining to the maintenance of the X-ray equipment. It also included critical examination packs for each X-ray set along with the required maintenance logs for X-ray equipment that were up to date.
- We saw that when dentists took X-rays they were justified, reported on and quality assured every time in accordance with national radiological guidelines. We saw dental records that confirmed this was the case.
- All health and safety policies and procedures were available and accessed through the trust's intranet.

Good

Are services safe?

- Each location had a well-maintained control of substances hazardous to health (COSHH) file in accordance with the COSHH regulations.
- All locations had in place protocols and procedures dealing with the main areas of clinical practice pertinent to the delivery of dental care. This included the provision of general anaesthesia and conscious sedation, radiation, infection prevention control, medicines management and dealing with common medical emergencies during dental treatment and reducing the risk of contracting Legionella during dental care.

Good

Are 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

We rated effective as good.

- We saw that staff delivered dental care that was effective, evidence based and focused on patients' needs.
- We found that clinical staff delivered care according to best practice guidelines in relation to dentistry; this included special care dentistry, conscious sedation for dentistry in primary care, paediatric dentistry and preventive dental care.
- We saw examples of excellent collaborative and team working by Sheffield Community Dental Services.
- Staff received professional development appropriate to their role and learning needs. Staff, registered with the General Dental Council (GDC), had frequent continuing professional development (CPD) and met their professional registration requirements.

Detailed findings

Evidence based care and treatment

- Lead clinicians were assigned across the service to ensure best practice guidelines were implemented and maintained. This included lead clinicians in conscious sedation, special care dentistry, pain and anxiety, dental care for patients suffering from spinal injuries, patients with severe mental health issues and clinical governance.
- The dentists, therapists and dental nurses used various national guidelines to ensure patients received the most appropriate care. This included the guidance produced by the British Society for Disability and Oral Health and the Faculty of General Dental Practice. Dentists and dental nurses we spoke with were fully conversant with these guidelines and the standards that underpinned them.
- Sheffield Community Dental Services delivered Dental general anaesthesia (GA) and conscious sedation services according to the standards set out by the dental faculties of the Royal Colleges of Surgeons and the Royal College of Anaesthetists 'Standards for Conscious Sedation in the Provision of Dental Care 2015.
- Special Care Dentistry that included domiciliary care and patients with complex medical and mental health and social impairments were delivered according to best practice as set out by the British Society for Disability and Oral Health (BSDH).
- Dental staff used the Department of Health's 'Delivering Better Oral Health Toolkit 2013' when providing preventative advice to patients on how to maintain a healthy mouth. This was an evidence based tool kit used for the prevention of the common dental diseases.

Pain relief

- Dentists assessed patients appropriately for pain and other urgent symptoms. For example, in cases of very young children where local anaesthesia was not appropriate for tooth extraction to relieve their pain general anaesthesia under the care of a hospital anaesthetist for the removal of teeth was used as an alternative.
- Patients were appropriately prescribed local anaesthesia by dentists for the relief of pain during dental procedures such as dental fillings and extractions

Nutrition and hydration

- Children and adults having procedures under GA were appropriately advised by dentists on the need to fast before undergoing their procedure. Patients undergoing conscious sedation also received appropriate advice from dentists and dental nurses regarding eating before this particular procedure.
- We saw examples of patient information leaflets detailing nutrition and hydration advice that had been developed by dental staff.
- We observed dentists and dental nurses providing this advice about healthy diets during consultations.

Patient outcomes

Good

Are services effective?

- The service carried out audits including dental radiography, infection control and clinical record keeping. These showed they were maintaining good professional standards.
- The sedation element of the service also carried out audit of Midazolam use and the use of the reversal agent (flumazenil).
- The service had developed a dental service for patients suffering a wide range of spinal injuries. These patients required a much-specialised approach to their dental care due to the nature of their injuries and the length of time spent in hospital.

Competent staff

- The clinical lead of the service encouraged dentists within the service to undertake additional professional training to provide services to an ever-increasing complexity of patient.
- We found that many of the dentists working in the dental service had taken additional postgraduate qualifications enabling them to deliver dental care to an increasingly complex cohort of patients. We saw that dentists had postgraduate master's degrees and diplomas in special care dentistry and paediatric dentistry and were on the General Dental Council's specialist register.
- To complement the specialist dentists, the Community Dental Service placed great emphasis on the benefit of using extended duty dental nurses. We found that 20 out of the 26 dental nurses had further training in conscious sedation and general anaesthesia in relation to dentistry, oral health promotion, dental radiography and cognitive behaviour therapy. Staff worked across the dental clinics to ensure clinics had appropriate staff grades at all times.
- Several of the community dental service staff were involved in the training of Foundation Dentists. Foundation training is the scheme whereby newly qualified dentists undergo an extended period of training and supervisionfollowing qualification.
- All staff had received regular annual appraisal. Records we saw showed that 100% of all staff had been appraised during 2015.

Multi-disciplinary working and coordinated care pathways

- We found for example that patients referred into the dental service for dental anxiety and phobia entered a nurse led pain and anxiety pathway. This pathway began with an assessment of the patient's dental anxiety. Following initial assessment, we found that patients were offered a variety of options; this included cognitive behaviour therapy, hypnosis, acupuncture, inhalation, oral and or intravenous sedation. This pathway had been cited in national dental literature as an example of exemplary practice.
- A collaboration between the Sheffield Community Dental Services, NHS commissioners, Dental Public Health consultants and local general dental practitioners led to the development of the Residential Oral Care Sheffield service for residents living in care homes. This collaboration was cited as good practice by the British Society for Disability and Oral Health. This service now covered 80 out of the 88 residential care homes who participate in the scheme in the city of Sheffield.
- We also found other care pathways in place such as those used for children attending Sheffield Special Schools where there were dental surgeries in situ.
- There was effective and collaborative working across disciplines involved in patient's care and treatment. For example, patients would often present with complex medical conditions requiring consultation with the patient's GP and or consultant physician or surgeon. We found that there were coordinated hospital theatre sessions for severe learning disability patients. During these sessions, patients were able to receive various speciality inputs that included dentistry, podiatry, orthopaedics and phlebotomy services.
- The service maintained close working relationships with the school nursing service, health visiting and learning disability teams to ensure that vulnerable groups requiring dental care can secure ready access to treatment and care readiliy.

Referral, transfer, discharge and transition

- There were clear referral systems and processes in place to refer patients into the service. The dental service and commissioners of services had developed this approach to ensure efficient use of NHS resources.
- Internal referral systems were in place, should the dental service decide to refer a patient on to other external services such as local maxillofacial services and Charles Clifford Dental Hospital and School of Dentistry

Good

Are services effective?

- Patients were seen by the dental service for single courses of treatment for sedation services or general anaesthesia (provided at the Royal Hallmshire hospital).
- Other patients were offered continuing care to ensure that their oral and dental needs were met on an ongoing basis, if they met the acceptance criteria of the service.
- On completion of treatment, dentists discharged the patient back to their own dentist so that the referring dentist could resume ongoing treatment. The dentists always sent a discharge letter to the referring practitioner following completion of treatment.
- Protocols were in place describing how patients were discharged from the service following intra-venous and relative analgesia conscious sedation. Protocols we saw assured us that patients were discharged in an appropriate, safe and timely manner.
- During the discharge process staff made sure the patient or responsible adult had a set of written post-operative instructions and understood them fully. Patients and their carers were given contact details if they required urgent advice and or treatment. The service had developed bespoke patient information leaflets that detailed these instructions.

Access to information

- All staff had access to best practice and evidence based guidance in relation to information governance through mandatory training and trust policy that was available on the trust intranet.
- Patients had access to a variety of information about their dental treatment in leaflet form. This information included pre and post-operative instructions and advice that helped them manage their dental care effectively before, during and after treatment.
- All the clinics we visited displayed information about the NHS charges for the treatment patients may receive and dental health promotion information.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The dental service had a lead clinician based at Limbrick Clinic who specialised in treating dental patients and coordinating the care of patients with mental health issues.
- Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. All staff received mandatory training in consent, safeguarding vulnerable adults, the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS).
- Staff we spoke with understood the legal requirements of the Mental Capacity Act 2005 and had access to social workers and staff trained in working with vulnerable patients, such as their safeguarding lead.
- There was a robust system for obtaining consent for patients undergoing General Anaesthesia, relative analgesia sedation and routine dental treatment.
- The consent documentation used in each case of general anaesthesia and relative analgesia sedation consisted of the referral letter from the general dental practitioner or other health care professional, the clinical assessment including a complete written medical, drug and social history. Full and complete NHS consent forms (1, 2, 3 or 4) were used by each dentist each as appropriate in every case during the consent process for each patient.
- We observed six patient assessment treatment records that demonstrated the systems and processes for obtaining consent by dentists were carried out.
- Where adults or children lacked the capacity to make their own decisions, staff sought consent from their family members.
- Where this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.

Good

Are services caring?

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

Summary

We rated caring as good .

- Patients and carers told us they had positive care experiences.
- Patients, families and carers felt well supported and involved with their treatment plans and staff displayed compassion, kindness and respect at all times.
- We also were shown an example of effective multidisciplinary working involving a patient with severe learning disabilities. This particular example is to be written up in a nationally peer reviewed dental journal as an example of exemplary multidisciplinary working in dentistry.
- We found staff to be hard working, caring and committed to the care and treatment they provided.
- Staff spoke with passion about their work and conveyed their dedication to what they did.
- Staff knew about the organisation's values and beliefs, including the organisation's commitment to patients and their representatives.

Detailed findings

Compassionate care

- During our inspection, we spoke with patients and their carers at Jordanthorpe clinic to gain an understanding of their experiences of care. They said they were very happy with the care and support provided by the staff.
- We observed staff treating patients with dignity and respect. We heard and observed staff using language that was appropriate to patients' age or level of understanding.
- Staff were considerate of people's anxieties and provided them with reassurance and were clear about the treatment. They allowed the patient time to respond if they were not happy or in pain.

Understanding and involvement of patients and those close to them

- The service oversaw the dental care of all of the patients suffering from spinal injuries and severe mental health issues in Sheffield. This involved close collaboration with the patients and their carers to obtain optimal outcomes for the patient.
- A range of literature was available for patients, relatives and/or their representatives and provided information in regards to their involvement in care delivery from the time of admission through to discharge from the general anaesthetic clinic. This included pre-treatment instructions, key contacts information and follow-up advice for when the patient left the clinic in leaflet form.
- Patients and their families were appropriately involved in and central to making decisions about their care and the support needed. We found that planned care was consistent with best practice as set down in national guidelines.

Emotional support

- Staff were clear on the importance of emotional support needed when delivering care.
- We found examples of exemplary care provided by the service. In one instance, a patient who suffered from severe learning disabilities was unable to tolerate any form of dental treatment and as a result, the patient's oral condition deteriorated. A multidisciplinary approach was required that took months of painstaking work to plan and execute a treatment plan to alleviate the patients oral condition. During this process, a very caring and empathetic approach was required for the patient and considerable emotional support was required by the patient's carers to see the process through to a satisfactory conclusion.
- We observed positive interactions between staff and patients during the domiciliary visits from Manor Clinic, where staff knew the patients very well and had built up a good rapport. We saw a number of patients with a spectrum of learning disabilities who required very sympathetic and caring staff helping patients to accept treatment in their best interests.
- Through our discussions with staff, it was apparent that they adopted a holistic approach to care concentrating

Good

Are services caring?

fundamentally on the patients social, physical and medical needs first, rather than seeing patients as a collection of signs and symptoms that required a mechanistic solution to their dental problems. This was illustrated by a comment made by a patient in a family and friends test returns during October 2015.This particularpatient very much disliked visits to the dentist but the attitude and caring nature of the staff made it bearable for the patient.

Outstanding

Are services responsive to people's needs?

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

Summary

We rated responsive as outstanding. This was because:

- For nearly all patients, effective multidisciplinary team working and links between clinics ensured patients received appropriate care at the right times and without avoidable delays. This was because of the 'can do' philosophy adopted by the staff who went that extra mile at all times.
- Patients from all communities could access treatment if they met the service's criteria.
- Sheffield Community Dental Service had developed a communication tool known locally as 'the widget sheets' enabling children with autistic spectrum disorders and other communication difficulties to accept dental treatment. An evaluation of this audit tool was published in the peer reviewed international scientific publication 'Journal for Disability and Oral Health in 2014.
- A dental service for patients in the Spinal Injuries Unit had also been developed by the service.
- There was a Residential Oral Care Sheffield service for residents living in care homes. This collaboration was cited as good practice by the British Society for Disability and Oral Health. This service covered 80 out of the 88 residential care homes who participate in the scheme in the city of Sheffield.
- A dental service was offered to Sheffield's homeless community who were treated through the 'Cathedral Archer Project'. The service could meet patients' needs because of the flexible attitude of all service members.

Detailed findings

Planning and delivering services which meet people's needs

- To facilitate the challenges facing the Community Dental Service because of the changes to patient demands, disease levels and demographic changes in the local Sheffield community, the Community Dental Service had merged with the Charles Clifford Dental Service in the previous 12 months. We saw that regular meetings with the clinical director of the Charles Clifford Dental Service and the clinical lead of the Community Dental Service took place to ensure that this merger was working effectively.
- There were systems and processes in place to identify and plan for patient safety issues in advance and included any potential staffing and clinic capacity issues.
- The community dental service gave patients a choice as to where they could be treated in each geographical area. The aim of this approach was to keep waiting times for treatment as short as practically possible.

Equality and diversity

- At each location we visited, the trust had made adjustments to buildings to enable patients with various disabilities to access the buildings easily. However, because of the age of some clinics, the design of the dental treatment rooms and the space available, the service was prevented from delivering modern special care dentistry. For example, Manor Clinic could not accommodate a 'wheelchair' tipping device or hoist to enable wheel chair user patients to receive optimal care.
- The training records indicated that all staff received regular update training in equality, diversity and human rights.

Meeting the needs of people in vulnerable circumstances

- The service was primarily a referral based specialised service providing continuing care to a targeted group of patients with special needs due to physical, mental, social and medical impairment.
- Patients are now entering old age with more teeth that have been restored with complex restorations. These patients require ongoing help by care home staff to help patients maintain a healthy dentition and prevent pain from poor gum health and dental decay. As part of the Residential Oral Care Sheffield servicescheme, the oral

health promotion team had developed a resource pack for care home staff to support the maintenance of oral health in elderly residents of care homes across Sheffield.

- A dental service was offered to Sheffield's homeless community who were treated through the 'Cathedral Archer Project'. The service could meet patients' needs because of the flexible attitude of all service members.
- A dental service for patients in the Spinal Injuries Unit had also been developed by the service.
- Sheffield Community Dental Service had developed a communication tool known locally as 'the widget sheets' enabling children with autistic spectrum disorders and other communication difficulties to accept dental treatment. An evaluation of this tool was published in the peer reviewed international scientific publication 'Journal for Disability and Oral Health in 2014.
- The dental service at Limbrick Clinic specialised in treating dental patients and coordinating the care of patients with mental health issues.
- There was a nurse led pain and anxiety pathway for patients referred into the dental service for dental anxiety and phobia. Following initial assessment, we found that patients were offered a variety of options; this included cognitive behaviour therapy, hypnosis, acupuncture, inhalation, oral and or intravenous sedation. This pathway had been cited in national dental literature as an example of exemplary practice.
- There was access to translation services.

Access to the right care at the right time

- General dental practitioners and other health professionals for short-term specialised treatment as well as long term continuing care referred patients to the community dental service. The service and commissioners had developed a set of acceptance and discharge criteria so that only the most appropriate patients were seen by the service.
- During our visits to each location, we observed clinics that ran to time and were not overbooked this minimised delay for patients. Patients were kept informed of any delays by dental staff and were offered the opportunity to rebook appointments if clinics overran.
- We found a small number of patients were waiting longer than 18 weeks to receive treatment. A senior dental nurse was responsible for organising and maintaining the waiting list; they explained that waiting times sometimes exceeded 18 weeks for patients with severe learning disabilities along with compromising medical conditions who were awaiting general anesthesia at the hospital.

Learning from complaints and concerns

- Written information in the form of posters were displayed in every clinic informing people how to raise concerns and complaints.
- At each dental staff meeting, complaints, both formal and informal, were discussed by staff to allow learning and reflection to take place. We saw examples of staff meeting minutes, which confirmed this had taken place.
- The service had a very low level of complaints; the emphasis was on de-escalation and local resolution of problems.

Outstanding

Are 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

We rated well led as outstanding. This was because:

- Staff members we spoke to told us the service was a good place to work and that they would recommend it to family members or friends.
- The dental service was well led locally and with organisational, governance and risk management structures in place.
- The staff we spoke with said they felt well supported by the clinical lead and that they could raise any concerns with their line managers.
- The clinical lead was forward thinking and was instrumental in the development of a number of innovative projects that had received national recognition.
- We saw examples of innovation across the key questions of effective, caring and responsive care, which was reflective of a well led service. These examples included the development of the nationally recognised case mix tool kit that describes the complexity of the patient seen in the community dental services. We saw that 'widget sheets' had been developed to facilitate improved communication between children with autism spectrum disorders and clinicians. The ROCS scheme ensured that as many patients as possible in residential care homes received equitable and effective dental care. The dental nurse led pain and anxiety service reduced the need for intravenous sedation for patients with dental anxiety and phobia.
- There was a clear vision and strategy for the service that was well developed and well understood by staff in all locations.
- The local management team was visible and the culture was seen as open and transparent.
- Staff were aware of the organisation's vision and way forward that include the PROUD philosophy developed but the Board at Sheffield NHS Foundation Trust.

Detailed findings

Service vision and strategy

- The service vision and strategy of the merged Community Dental Services and Charles Clifford Dental Service was an on going project, at the time of our visit we did not see a written strategy document. However from our discussions with senior clinicians in the Community Dental Service the merger appeared to be successful.
- Staff were aware of the organisation's vision and way forward that included the PROUD philosophy developed by the Board at Sheffield NHS Foundation Trust.
- We found that senior clinicians from the Community Dental Services provided 'in reach' services to the Charles Clifford Dental Service such as conscious sedation and contributing to the undergraduate and post graduate teaching programme of the Charles Clifford dental hospital and school of dentistry. These 'in reach' services enabled clinicians from the Community Dental Service to build effective working relationships with staff at Charles Clifford Dental Services. The clinical lead of the Community Dental Service took part in the executive meetings between the community service and the dental hospital and school further enhancing effective partnership working.

Governance, risk management and quality measurement

- The clinical lead maintained overall responsibility and accountability for the running of the service.
- The Community Dental Services are part of the oral and dental clinical directorate within the Head and Neck care group.The Head and Neck care group is one of nine within the trust. Routine; performance, governance and professional issues, were managed by the clinical directorates with the director of strategy and operations holding clinical directorates accountable for their performance.
- The dental management team were responsible for passing information upwards to the trust managers and downwards to the clinicians and dental nurses on the

front line. The structure in place appeared to be effective which was confirmed when we spoke to various members of staff and the examples of the minutes of staff meetings we observed. The dental management team were responsible for the safe implementation of policies and procedures in relation to infection control, dealing with medical emergencies and incident reporting.

- The dental service has in place a set of governance procedures that aimed to satisfy all UK and European legislation. Policies and procedures satisfying these criteria were available to all staff on the trust's intranet in the form of a document folder. Staff we spoke with were aware of this document folder and were able to show us how they accessed the information.
- We found that the systems for monitoring the quality care were always complete and up to date. This included the recommended maintenance schedules, checks of dental equipment, medicines and materials used for the provision of dental care.

Leadership of this service

- We spoke to dentists, dental nurses and administrative staff who said the service had a forward thinking and proactive clinical lead who was well supported by senior managers within the Trust.
- We found that the relationship between the staff and the local management team was strong, and staff members at all levels reported there was an open door policy. Staff told us that if they had concerns regarding the service they would feel comfortable speaking directly to them.
- The clinical lead had fostered a culture of devolving responsibility to other appropriate individuals within the service. This in turn had engendered a culture of individual responsibility and accountability throughout the service.
- Senior dentists, who had worked in the service for many years, told us how the clinical lead would identify at an early stage the potential of new members of staff. These new staff members were encouraged to take the lead in various roles such as conscious sedation, paediatric special care dentistry and the pain and anxiety service.
- Staff confirmed that they felt valued in their roles within the service and the local management team were approachable, supportive and visible at all times.

Culture within this service

- We observed staff who were very passionate and proud about working within the service and providing good quality care for patients.
- The culture of the service demonstrated to be that of continuous learning and improvement. At each clinic we visited, we saw that staff worked well together and there was respect between all members of the dental team.
- The morale of the staff appeared good at each clinic with staff adopting a positive 'can do' philosophy about their practice and the challenges they faced.
- Staff were proud to work in the service and were committed to provide the best care possible for every patient. This was evident when we observed the patient treatment sessions during a domiciliary session carried out by the team from Manor Clinic. During this session, we observed the dentist and dental nurse providing dental care to a number of patients who had severe end of the learning disabilitieswith complex needs.
- The staff roles and responsibilities were clearly defined with a sufficient skill mix of staff across all staff grades and all staff spoke of their commitment to ensuring patients were looked after in a caring manner.

Public engagement

- It was apparent through discussions with staff that community dental services worked very much with the individual because of their often very complex needs. This also involved relatives and carers in helping the person to participate in decisions about the treatment and care. Very often, these patients had severe communication difficulties and mental health issues that meant conventional public engagement tools were unsuitable for these groups of patients.
- However, we did see the latest Family and Friends Test analysis for October 2015 that showed patients were extremely likely or likely to recommend the service to family or friends.

Staff engagement

Outstanding

Are services well-led?

- Team meetings demonstrated that the service engaged all staff. For example, we saw the agenda and minutes of the dentist's clinical peer review meetings for conscious sedation. We saw once such meeting that had taken place in July 2015. This particular meeting dealt with the analgesic and physiological effects in conscious sedation with different nitrous oxide concentrations. We also saw the forthcoming dates of meetings for the year 2016. During these meetings, clinicians were able to discuss current issues in relation to clinical dentists as well as bringing clinical cases of interest to the group for wider discussion about different approaches to treatment. We also saw examples of the dental operational board meetings, and dental nurse meetings. Twice each year the whole of the service meets giving an opportunity for all staff to meet in one place at the same time to exchange news and views.

Innovation, improvement and sustainability

- The clinical lead was instrumental in the development of a number of innovative projects and benchmarking tools that have been recognised nationally by dentistry and the NHS. These included, the development of the case mix tool kit, 'widget sheets', ROCS scheme and the dental nurse led pain and anxiety service.
- The local management of the service in accessing and attending training was supportive to staff. Supported access ensured that dental staff had the appropriate skills and training to make effective clinical decisions and treat patients in a prompt and timely manner.
- All staff had the opportunity to take further qualifications or undertake further study to enhance the patient experience dependant on the outcome of their appraisal and subsequent personal development plan.
- A senior nurse we spoke with described how a number of dental nurses had undergone additional training in dental radiography, general anaesthesia and conscious sedation, cognitive behaviour therapy and oral health promotion that enabled the service to provide enhanced care for patients.
- The examples of innovation in the areas of clinical effectiveness, caring and responsiveness were indicative of the quality of the local leadership within the service.