

Wye Valley NHS Trust

RLQ

# 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)
RLQ21	Gaol Street Clinic		
RLQX3	Dishley Street Dental Clinic	<Placeholder text>	<Placeholder text>
RLQX2	Asda Health Centre	<Placeholder text>	<Placeholder text>
RLQ08	Ross Community Hospital	<Placeholder text>	<Placeholder text>







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

# Summary of findings

## Ratings

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

# Summary of findings

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# Summary of findings

## Overall summary

### **Overall rating for this core service Good I**

We found dental services provided safe and effective care. Patients' were protected from abuse and avoidable harm. Systems for identifying, investigating and learning from patient safety incidents were in place.

Dental services were effective and focussed on the needs of patients and their oral health care. We found the overall care provided at the service to be good. We observed good examples of effective collaborative working practices within the service. The service was able to meet the needs of the patients who visited the clinics for care and treatment because of the flexible attitude of all members of the service.

Effective multidisciplinary team working ensured patients were provided with care that met their needs and at the right time. This was achieved by thorough effective management of resources.

At the time of inspection we saw no evidence to indicate that the service collected referral to treatment times for urgent and routine referrals, only for patients requiring general anaesthetic. This meant that the services established systems and processes did not operate effectively to monitor all the dental services waiting time data. Waiting times for patients requiring general anaesthetic ranged between six and 14 weeks. This met the national 18 week referral to treatment target.

The service was well-led. Organisational, governance and risk management structures were in place. The operational management team of the service were visible and the culture was seen as open and transparent. Staff were aware of the vision and way forward for the organisation and said that they generally felt well supported and that they could raise any concerns.

# Summary of findings

## Background to the service

### Information about the service

Wye Valley NHS Trust provides a dental service for all age groups who require a specialised approach to their dental care and are unable to receive this in a general dental practice. The service also provides urgent in hours and out of hours service through their network of dental access centres.

The service provides oral health care and dental treatment for children and adults that have an impairment, disability and/or complex medical condition. This includes people with a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability, and those who are housebound.

Gaol Street Clinic provides additional services, for example, a sedation service where treatment under a local anaesthetic alone is not feasible and conscious sedation is required

General anaesthetic (GA) services are provided for children in who were in pain where extractions under a local anaesthetic would not be feasible or appropriate such as in the very young, the extremely nervous, children with complex needs or those requiring several extractions.

Adults who require general anaesthesia because they have complex needs are referred to Birmingham Dental Hospital for this type of care.

There are four registered dental service locations provided by the Wye Valley NHS Trust.

During our inspection we visited two registered locations which provide a special care dental service for all age groups and urgent care facilities:

- Dishley Street Dental Clinic
- Gaol Street Clinic

During our inspection we did not visited two registered locations:

- Asda Health Centre
- Ross Community Hospital

Some dental services are also provided from Ledbury Health and Community Care Centre, Kington Court and Ewyas Harold although these are not registered locations.

## Our inspection team

Our inspection team was led by:

**Chair:** Dr Peter Turkington, Medical Director, Salford Royal NHS Foundation Trust

**Head of Hospital Inspections:** Helen Richardson, Care Quality Commission

The team included one CQC inspector and a specialist dental adviser.

## Why we carried out this inspection

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

# Summary of findings

## How we carried out this inspection

We carried out a comprehensive inspection of Wye Valley NHS Trust. We spoke with patients who used the service on the day of our inspection, we also spoke with members of staff, including the service lead, the infection control lead, dentists, dental nurses and reception staff.

We review policies, procedures, dental records and made observation on how the service was run on the day of the 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 carried out an announced visit on 23 September 2015. During the visit we talked with patients. We observed how patients were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with patients and carers, who shared their views and experiences of the core service.

## What people who use the provider say

During and post inspection we talked to patients within the dental services. All of the responses we received were very positive about the services patients had received. Examples of comments included:

"Staff are excellent."

"No, I don't have to wait long when I arrive for an appointment."

"It's easy to make an appointment."

"The dentist is excellent."

"I have never had to make a complaint."

"Staff are always very polite and friendly."

## Areas for improvement

### Action the provider **MUST** or **SHOULD** take to improve

The trust should ensure the dental service collects referral to treatment times for all types of referrals.

Wye Valley NHS Trust

# Community dental services

**Detailed findings from this inspection**

**Good** 

## Are services safe?

**By safe, we mean that people are protected from abuse**

Services were safe because there were systems for identifying, investigating and learning from patient safety incidents and an emphasis in the organisation to reduce harm or prevent harm from occurring.

Staffing levels were safe in the clinics with a good staff skill mix across the whole service. Staff were aware of the safeguarding policy and had received training at the appropriate level with regards to safeguarding vulnerable adults and children.

There were appropriate systems in place for the secure storage and management of medicines. Dental equipment was clean, well maintained and had annual services carried out.

### **Safety performance**

- We found the dental service had safety systems in place to help ensure the safety of staff and patients. This included for example having infection prevention and control protocols, a fire policy, Control of Substances Hazardous to Health protocols, monitoring of Medicines and Healthcare products Regulatory Agency (**MHRA**) alerts, procedures for using equipment safely, health and safety procedures and risk assessments.

- Risk assessments had been undertaken for issues affecting the health and safety of staff and patients using the service. This included risks associated with allergic reactions, clinical waste, use of equipment and use of biological agents.

### **Incident reporting, learning and improvement**

- We found the dental services protected patients from abuse and avoidable harm as staff were confident about reporting serious incidents and providing information to the clinical director or dental services manager if they suspected poor practice, which could harm a patient.
- All staff were familiar with the reporting system and could provide examples of reporting incidents and the lessons learnt. Staff told us they were comfortable about raising concerns with the management of the service. Staff were aware of the duty of candour and knew what action to take if they had any concerns about specific incidents that occurred.
- Staff told us incidents, accidents or near misses were reported onto the organisations risk management system, where it was possible to collate and report on any trends.



# Are services safe?

- The lead dental nurse at Gaol Street Clinic described the electronic system of incident reporting and demonstrated the computer algorithm for reporting incidents. The system appeared simple and straight forward to use.
- The outcomes of such incidents were cascaded upwards to the clinical director and dental services manager and downwards to departmental staff through the regular team meeting structures. For example, we saw that the protocol around the handling of keys for a medicine cabinet were reviewed and discussed with staff following an incident that had occurred. This mechanism ensured that all members of the service team were able to learn lessons and implement appropriate remedial measures wherever possible to prevent harm to patients and staff alike.
- We found mechanisms were in place to monitor and report safety incidents, including “never events”. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

## Safeguarding

- Staff we spoke with were aware of the safeguarding policy and had received training at the appropriate level with regards to safeguarding vulnerable adults and children according to the ‘Child Protection and the Dental Team’ published by the Committee of Postgraduate Dental Deans and Directors (COPDEND).
- 97% of staff had received adult safeguarding training level 1, including dental receptionists and administrative staff.
- 100% of staff had received child safeguarding level 1 and 97% child safeguarding level 2. Five staff had received child safeguarding level 3 training.
- The staff we spoke to were knowledgeable about safeguarding issues in relation to the community they served. All of the staff we spoke to were aware of the safeguarding concerns that could impact upon the delivery of dental care. This included children who presented with high levels of dental decay which could indicate that a child was suffering from neglect. Staff we spoke with explained how they used their system of ‘no access/unseen child forms’ when vulnerable paediatric

patients who had high treatment needs failed to attend appointments for dental treatment. These letters were then shared with appropriate agencies such as the Local Authority Children’s Services when appropriate.

- There had been no incidents that required reporting as a safeguarding in the last 12 months.
- Where adults or children lacked the capacity to make their own decisions, staff sought consent from their family members or representatives. 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.

## Medicines

- A comprehensive recording system was available for the prescribing and recording of medicines. The dental treatment records we viewed were complete, provided an account of medicines prescribed, and demonstrated that patients were given their medicines as prescribed. The batch numbers and expiry dates for local anaesthetics were always recorded in the sample of clinical notes we viewed.
- We found that medicines for emergency use were available, in date and stored correctly on designated ‘crash trolleys’ at each of the sites we visited.
- We found medicines used for intravenous sedation were stored safely and the service had developed a robust system of stock control for the protection of patients at Gaol Street Clinic where intravenous sedation services were carried out.
- Medicines used for sedation were recorded on an intravenous sedation procedural record card. We saw two randomly chosen patient dental treatment records where sedation had been carried out and information about sedation had been recorded appropriately.
- Prescription pads were stored securely to prevent incidents of prescription fraud.

## Environment and equipment

- We noted that the surgeries used for patient treatment contained dental equipment that was clean, well maintained and had annual services carried out. We saw that equipment used for the monitoring of patients during intravenous sedation had check lists attached to them showing that daily checks were carried out and when the next maintenance schedule was due. The service maintained sufficient numbers of all equipment.

## Are services safe?

This was demonstrated when we observed the dedicated instrument storage rooms appropriate for the storage of processed instruments and consumable materials. We saw evidence of this at all the locations we visited.

- At every site we visited there was a range of suitable equipment which included an automated external defibrillator, emergency medicines and oxygen available for dealing with medical emergencies. This was in line with the Resuscitation Council UK and British National Formulary (BNF) guidelines. The emergency medicines were all in date and stored securely, with emergency oxygen, in a central location known to all staff. A check list monitoring the expiry dates of the emergency medicines was present in each storage cabinet at each location we visited and was signed by the responsible dental nurse. This ensured that the risk to patients during dental procedures was reduced and patients were treated in a safe and secure way.
- At each site we visited we were shown a well maintained radiation protection file. This 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 three yearly maintenance logs. A copy of the local rules was displayed with each x-ray set. The clinical records we saw showed that when dental x-rays were prescribed they were justified, reported on and quality assured every time. This ensured that the service was acting in accordance with national radiological guidelines. The measures described also ensured that patients and staff were protected from unnecessary exposure to radiation.
- Staff showed us how the service checked that the three autoclaves (equipment used to sterilise dental instruments), were working effectively. They showed us the paperwork which staff used to record the essential daily and weekly validation checks of the sterilisation cycles. These were fully completed and up to date. We observed maintenance information showing that the autoclaves were maintained to the standards set out in current guidelines.

### Quality of records

- At all the sites we visited clinical records were kept securely so that confidential information was properly protected.

- Throughout our inspection visits we looked at a sample of dental records across the service. The hard copy records were well-maintained and provided comprehensive information on the individual needs of patients such as; oral examinations; medical history; consent and agreement for treatment; treatment plans and treatment records.
- Clinical records viewed were clear, concise and accurate and provided a detailed account of the treatment patients received. Patient safety and safeguarding alerts were also thoroughly recorded. For example allergies and reactions to medication such as general anaesthetic.
- The computerised records were secured by password access only. 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 general public. This was in accordance with data protection regulations.

### Cleanliness, infection control and hygiene

- The service used a system of local decontamination at all sites for the processing of contaminated instruments used during treatment. The systems in place ensured that the service was meeting HTM 01 05 [HTM 01 05 is a document issued by the Department of Health that details guidelines for decontamination and infection control in dental care. This includes guidance for protective equipment to be used, procedures that should be in place and procedures for minimising cross infection]. The service manager was the infection control lead.
- Staff at centres we visited where local decontamination took place 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 and for the transfer, processing and storage of instruments to and through designated on-site decontamination rooms. The staff we spoke to were aware of current infection prevention and control guidelines and we observed good infection prevention and control practices, such as:
- Hand washing facilities and alcohol hand gel were available throughout the clinics.

## Are services safe?

- Staff were following hand hygiene and 'bare below the elbow' guidance. This was in accordance with trust policy.
- Staff wearing personal protective equipment, such as gloves and aprons, whilst delivering care and treatment.
- Suitable arrangements for the handling, storage and disposal of clinical waste, including sharps.
- Cleaning schedules in place and displayed for each individual treatment room. These were complete and were signed by the responsible dental nurse.
- Clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- We observed the daily, weekly and quarterly test sheets for the autoclaves and washer disinfectors along with the maintenance schedules at each location where local decontamination was carried out. These were signed by either the responsible dental nurse or the external company carrying out the quarterly validation checks.
- The segregation and storage of dental waste was in line with current guidelines laid down by the Department of Health (in accordance with HTM 07 01 The Department of Health's safe management of healthcare waste guidance).
- The use of safer sharps and the treatment of sharps waste were in accordance with current guidelines from the Health and Safety Executive.
- Sharps injury protocols were on display in each clinical area and understood by the staff we spoke to. We observed that sharps containers were well maintained and correctly labelled.

### Mandatory training

- Staff across the service had received mandatory training and profession specific training. This included safeguarding, infection prevention and control, moving and handling, medicines management and the Mental Capacity Act 2005 awareness.
- Staff undertook yearly training in either intermediate life support techniques or basic cardiopulmonary resuscitation appropriate to the clinical grade of the member staff. For example all dentists and dental therapists undertook training in intermediate life support techniques and those involved in sedation or general anaesthetic services also undertook training in

paediatric 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.

- There was a system in place to effectively monitor this training and flag up when refresher training was required.
- Training records confirmed that all staff working in the clinics had attended the required mandatory training.

### Assessing and responding to patient risk

- Dentists used a risk based assessment when setting patients dental recall intervals using NICE recall guidance. Dental care records we sampled showed that dentists assessed patients' risks in relation to mouth cancer, dental decay, gum disease and motivation and set the recall interval accordingly in discussion with patients.
- We saw that audits were carried out of records to ensure dentists were assessing risks following completion of audits action plans were drafted and information from audits were shared with staff during meetings and supervisions with individual members of staff.
- To prevent wrong site tooth extraction, the service adopted a number of fail-safe processes to prevent such incidents. This included thorough cross referencing of the clinic notes with operating lists during each theatre session as well as adopting the general principles set out on the 5 Steps to Safer Surgery guidelines for preventing wrong site surgery.
- We asked the trust for the policy if a patient had adverse reactions to GA or deteriorated during a procedure. However, this was not provided.

### Staffing levels and caseload

- We found there were sufficient numbers of dentists, dental nurses and other staff to meet the needs of the patients that used the service.
- There were no dentist or nurse vacancies. No locum or agency staff had been used in the past 12 months.
- There were 0.8 whole time equivalent (WTE) receptionist and 0.8 WTE decontamination worker vacancies which had been advertised.
- Access to all of the clinics across the area was maintained for patient care and treatment through careful management of the staff rotas. It appeared from

## Are services safe?

looking through the appointment diaries on the computerised system at the two sites we visited that appropriate appointment slots were allocated for both patient assessment and treatment sessions.

- The dentists we spoke with felt that they had adequate time to carry out clinical care of the patient.

### Managing anticipated risks

- Patients undergoing intravenous sedation had important checks made prior to sedation; this included a medical history, height, weight and blood pressure. These checks were carried out to determine if patients were suitable to undergo this type of procedure. The records we viewed demonstrated that during the sedation procedure important checks were recorded at regular intervals during the operation and included pulse, blood pressure, breathing rates and the oxygen saturation of the blood. This was carried out using a specialised piece of equipment known as a pulse

oximeter. This information was recorded on bespoke procedural recording forms developed by the service. These checks were in line with current good practice guidance from the Society for the Advancement of Anaesthesia in Dentistry. This demonstrated that sedation was carried out in a safe and effective way.

- The service had a named radiation protection adviser and radiation protection supervisor for each location. This was to ensure that the service was complying with legal obligations under Ionising and Radiation Regulation (IRR) 99 and Ionising and Radiation Medical Exposure regulation (IRMER) 2000 radiation regulations. This included the periodic examination and testing of all radiation equipment, the risk assessment, contingency plans, staff training and the quality assurance programme. The services' named radiation protection supervisor ensured that compliance with Ionising Radiation Regulations 99 and IRMER 2000 regulations was maintained.

## 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.

Services were effective, evidence based and focussed on the needs of the patients. We saw examples of good collaborative team working.

Staff received professional development appropriate to their role and learning needs. Staff understood their responsibilities in relation to Mental Capacity and Deprivation of Liberty legislation.

Staff who were registered with the General Dental Council (GDC) had frequent continuing professional development (CPD) and were meeting the requirements of their professional registration.

### Evidence based care and treatment

- Dental general anaesthesia (GA) and conscious sedation was delivered 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'. The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. The practice showed us that they had rubber dam kits available for use when carrying out endodontic (root canal) treatment. The dentists we spoke with confirmed that they used a rubber dam as far as practically possible. Domiciliary dental care was provided across the sector using the standards set out in the Guidelines for Domiciliary Care by the British Society for Disability and Oral Health (BSDOH).
- Dentists we spoke with on the day of our visit were aware of various best practice guidelines. For example they were aware of National Institute for Health and Care Excellence (NICE) guidelines. The dentists were aware of various Faculty of General Dental Practice Guidelines. This included guidelines in relation to selection criteria for dental X-rays and clinical examination and record keeping.

- Preventive care across the service was delivered using the Department of Health's 'Delivering Better Oral Health Toolkit 2013'. Prevention was tailored to each individual patient using a risk based approach. Preventive treatment and advice included: the placement of fissure sealant restorations to prevent decay from occurring in the biting surfaces of teeth, fluoride varnish applications to teeth and the prescription of high concentrated fluoride tooth pastes to high risk patients.

### Patient outcomes

- We looked at clinical audits that had been undertaken and saw that they had been reviewed and action plans devised to improve outcomes for patients.
- For example an audit of referrals to dental therapists was reviewed and systems put in place to increase the number of these types of referrals. We found that action plans were implemented following the completion of audits.
- An April 2015 audit of records had found that 100% of the dentists had recorded the necessary information in regards to mouth cancer risk.
- Staff described to us clear plans to improve patient outcomes, including working with other teams within the trust and other services, where appropriate.

### Competent staff

- All staff had received training appropriate to their posts, for example, dental nurses had taken the National Examining Board for Dental Nurses Certificate in Dental Nursing.
- Dentists and dental nurses had undertaken post qualification courses in areas such as sedation and dental radiography and fluoride varnish applications.
- Wherever possible the trust funded or part funded development studying for staff. Senior managers arranged for staff to attend briefing sessions run by the trust as development opportunities. For example, we saw one dental nurse had been sent on a specialist sedation course.

# Are services effective?

- 96% of staff had received an appraisal in the previous 12 months.

## Multi-disciplinary working and coordinated care pathways

- The GA and sedation care was prescribed using an approved care pathway approach. Patients entered a recognised pathway of: cognitive behavioural therapy, Tender Loving Care (TLC) and either intravenous sedation or inhalation sedation, dependent upon each individual patient's medical, social or clinical need.
- The service was relatively self-contained because the department contained a diverse mix of well trained and experienced dental staff. However the nature of the patients and their complex needs required multidisciplinary working. For example patients would often present with complex medical conditions requiring consultation with the patient's GP and or consultant physician or surgeon. The service also carried out joint general anaesthetic sessions with other specialities.
- 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 could secure access to treatment and care as required. This close working also enabled patients who may have been vulnerable to safeguarding issues to be flagged up so staff were aware of specific needs when they received a service.

## Referral, transfer, discharge and transition

- The service maintained a list of patients within the service for continuing care. This was appropriate because some patient groups such as patients with a learning disability and long term medical conditions which could have compromised dental care would not be able to access dental care in a 'high street' setting.
- Patients who were seen for single courses of treatment for sedation services or GA were discharged back to their referring general dental practitioner with a comprehensive discharge letter detailing the treatment carried out by the service.
- Where necessary patients with very complex needs were referred to dental hospitals in Birmingham, Bristol or Cardiff.

## Access to information

- Staff could access trust and professional guidance within the intranet.
- Information about the service locations and opening times was available on the service website for patients to access.

## Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- 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 had received mandatory training in consent, safeguarding vulnerable adults, the Mental Capacity Act 2005 and Deprivation of Liberty 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.
- The staff we spoke with understood their responsibilities in relation DoLS. They were aware of how they would support a patient who lacked the capacity to consent to dental treatment and understood they could not deprive patient's liberty.
- Staff had a good understanding of consent and applied this knowledge when delivering care to patients. Staff we spoke with had received training around consent and had the appropriate skills and knowledge to seek consent from patients or their representatives. We observed positive interactions between staff, patients and/or their relatives when seeking verbal consent and the patients we spoke with confirmed their consent had been sought prior to care being delivered.
- We observed that an effective system for obtaining consent was carried out for patients undergoing GA, conscious sedation and routine dental treatment. A review of a sample of dental care records showed that documentation used in each case of intravenous 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 completed NHS consent forms were used as appropriate in every case.
- Pre-operative and post-operative check lists and patient information leaflets detailing pre-operative and post-operative instructions for the patient to follow, completed the consent process.



## Are services caring?

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

Patients told us they had positive experiences of care at each of the clinics we inspected. Patients, families and carers felt well supported and involved with their treatment plans and staff displayed compassion, kindness and respect at all times.

We found staff to be hard working, caring and committed to the work they did. Staff spoke with passion about their work and were proud of what they did. Staff knew about the organisation's commitment to patients and their representatives and the values and beliefs of the organisation they worked for.

### Compassionate care

- Staff told us that effective communication and collaboration between all members of the team ensured trust and respect in those delivering prescribed treatment and care. Patients, their relatives and carers were all positive about the care and treatment they had received from the dental team.
- We observed all staff treating patients with dignity and respect.
- Staff at reception desks were helpful, caring and supportive when talking to patients. We observed that they took extra time when dealing with patients that appeared to be anxious.
- Patients we spoke with on the day of the inspection said staff were friendly and caring.

### Understanding and involvement of patients and those close to them

- The patients we observed were given explanations about their dental treatment in language that they

could understand. We saw kind, gentle and compassionate care being given to patients. Patients told us they were pleased they were about the care they had received.

- 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 by national guidelines. We found that relatives and/or the patient's representative were involved in discussions around the care and treatment where it was appropriate.
- 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 GA clinic. This included: Pre-treatment instructions, key contacts information and follow-up advice for when the patient left the clinic. Patients told us staff were kind and attentive. They felt they were kept well informed about their care and were involved in making decisions about their treatment at each stage.
- Records showed that treatment options were discussed with patients and patients confirmed that this information was discussed in a way they understood.

### Emotional support

- Staff were clear on the importance of emotional support needed when delivering care. We observed positive interactions between staff and patients.
- The staff all adopted a holistic approach to care concentrating fundamentally on the patients social, physical and medical needs first, rather than seeing patients as a collection of signs and symptoms which required a mechanistic solution to their dental problems.

# Are services responsive to people's needs?

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

The service was responsive to patient's needs and people from all communities could access treatment if they met the service's criteria. Effective multidisciplinary team working and effective links between the different clinics, ensured patients were provided with care that met their needs, at the right time and without avoidable delay.

At the time of inspection we saw no evidence to indicate that the dental service collected referral to treatment times for urgent and routine referrals, only for patients requiring general anaesthetic. This meant that the services established systems and processes did not operate effectively to monitor all the dental services waiting time data. Waiting times for patients requiring general anaesthetic ranged between six and 14 weeks. This met the national 18 week referral to treatment target.

## Planning and delivering services which meet people's needs

- 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. All patients were given a choice as to where they could be treated.

## Equality and diversity

- Information leaflets and posters were available and accessible for patients at all the locations visited. There were leaflets printed in other languages for patients whose first language was not English.
- A translation service was available if interpretation was required.

## Meeting the needs of people in vulnerable circumstances

- Over a period of years, the service had moved from a traditional community dental service, that was one of seeing mainly healthy school children to one which was a mixture of referral based specialised service, and urgent care services, providing continuing care to a targeted group of patients with complex needs due to physical, mental, social and medical impairment.
- The locations we viewed as part of our inspection were fully accessible for patients with a physical disability or who required the use of a wheelchair.

- We saw that the service used models of tooth brushing, pictures and drawings to help people with learning disabilities understand treatments and options.
- Accessibility to the clinics we visited was good with car parking available on each site.

## Access to the right care at the right time

- At the time of inspection we saw no evidence to indicate that the dental service collected referral to treatment times for urgent and routine referrals. This meant that the services' established systems and processes did not operate effectively to monitor dental services waiting time data.
- Staff were unable to explain why this data was not collected. They did not have an alternative method of determining how long patients were waiting to be seen.
- The dental service did collect referral to treatment times for patients requiring general anaesthetic. The trust informed us that for November 2015, waits ranged between six and 14 weeks. This met the national 18 week referral to treatment target.
- Staff reported that patients were referred to the service for short-term specialised treatment or urgent care services. Acceptance and discharge criteria were in place so that only the most appropriate patients were seen by the service. On completion of treatment, patients were discharged either to the patient's own dentist so that ongoing treatment could be resumed by the referring dentist or they were directed to NHS dentists accepting new patient referrals. However the service retained groups of patients for continuing care where it was felt that continuing care by 'high street' dental practice was not feasible or in the best interests of the patient.
- We discussed with staff during our visit how patients were discharged from the service after GA, intravenous sedation or relative analgesia conscious sedation. We were assured that patients were discharged in an appropriate, safe and timely manner. During the discharge process clinical staff made sure the patient or responsible adult had a set of written post-operative instructions and understand them fully. They were also



## Are services responsive to people's needs?

given contact details if they required urgent advice and or treatment. This was corroborated by observing patient records where sedation had been given and talking to staff during our visit.

- There was sufficient clinical freedom within the service to adjust time slots to take into account the complexities of the patient's medical, physical, psychological and social needs. Patients told us they did not have to wait long for an appointment. They believed the dentist spent sufficient time with them to deal with the problem they came to see them about.
- The service was available seven days a week. Appointment bookings were available Monday to Friday 9am to 5pm and drop in clinics without appointments Monday to Friday 5.30pm to 8pm, and 9am to 11.30am at weekends. Drop in clinics were provided on a sit and wait basis.

### Learning from complaints and concerns

- The service had effective arrangements in place for handling complaints and concerns. There was a complaints policy that had been drafted in 2013 and was scheduled to be reviewed in October 2016. The policy included details of organisations patients could contact if they were not happy with the response received for the trust.
- There had been seven complaints across the service in the last year and they had been dealt with in line with the policy. We saw that the service apologised to patients when mistakes were made and learnt from mistakes.

# 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.

The service was well-led with organisational, governance and risk management structures in place. However, there was no specific dental representation on the trusts board.

The local management team were visible and the culture was seen as open and transparent. Staff were aware of the way forward and vision for the organisation and said that they felt well supported and could raise any concerns with their line manager. All staff told us that it was a good place to work and would recommend to a family member or friends.

## Service vision and strategy

- It was evident from discussions with the team that the service was well led with a forward thinking and proactive clinical director and dental services manager.
- However, we found there was no written strategy specifically for dental services.

## Governance, risk management and quality measurement

- The use of senior dental nurses as clinic leads appeared to be a good innovation. The clinic leads were responsible for the day to day running of each clinic. They were responsible for cascading information upwards to the senior dental management team and downwards to the clinicians and dental nurses on the front line. Clinic leads would be responsible for the safe implementation of policies and procedures in relation to infection control, dealing with medical emergencies and incident reporting.
- The service undertook quality audits. This included audits on infection control, dental care records and radiography.
- The service had an effective system to regularly assess and monitor the quality of service that patients received. Records of various checks, observation of completed audits and discussion with the senior team management confirmed a strong commitment to quality assurance and maintaining high standards.

## Leadership of this 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. Clinicians stated that there was an open door policy with respect to the clinical director who was always on hand to provide professional support and advice.
- Staff said there was visible leadership across the organisation and expressed confidence that any concerns raised with senior managers would be acted on. 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.

## Culture within this service

- We observed staff who were passionate and proud about working within the service and providing good quality care for patients.
- Staff sickness rates averaged 2.9% over the previous 12 months. This was better than the trust target of 3%.

## Public engagement

- At the time of the inspection the service was undertaking the Friends and Family Test. The results showed that 79% of patients in August 2015 said they would be likely, or extremely likely to refer friends to the service.

## Staff engagement

- All of the staff we spoke to were very patient focused and provided patient centred care
- Staff told us meetings were held regularly to discuss issues in the service and provide updates on factors affecting clinical practice. We saw that these meetings were used as an opportunity to let staff know about the ongoing business of the service and incidents. For example we saw that managers discussed significant incidents with staff at 2015 meeting.

## Innovation, improvement and sustainability

- The culture of the service demonstrated to be that of continuous learning and improvement. All staff had the opportunity to take further qualifications to enhance the

## Are services well-led?

patient experience dependant on the outcome of their appraisal. The clinical lead described how the dental nurses had undergone additional training in dental radiography, fluoride varnish applications and sedation which enabled the service to provide enhanced care for

patients. Although we were told that these opportunities had been restricted to free briefings that senior managers could source following reductions in training funding.