Norfolk Community Health and Care NHS Trust

Community Dental Services

Community dental services

Quality Report

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Date of inspection visit: To Be Confirmed
Date of publication: 19/12/2014

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

Summary of findings

Ratings

Overall rating for Dentistry	Good
Are Dentistry safe?	Good
Are Dentistry effective?	Good
Are Dentistry caring?	Good
Are Dentistry responsive?	Good
Are Dentistry well-led?	Good

Summary of findings

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Summary of findings

Overall summary

There were systems and processes in place to keep people safe. Staff knew how to report incidents and there was evidence of learning from these. There were good infection prevention and control procedures in place and staff took responsibility for this. Staff demonstrated an in depth knowledge of decontamination best practice.

Equipment was serviced and was checked before use. We found the temperature checks of the medicines refrigerators were not consistently taking place but this was being addressed. Apart from drugs stored in the refrigerator, other medicines were stored safely. Staff could describe their responsibilities under safeguarding patients in their care and we found where concerns had been raised the appropriate procedures had been followed.

Records were well maintained and consent was taken prior to procedures being carried out. There were procedures in place to assess and respond to patients risks. Patients medical history was obtained and individual risks were identified. Emergency equipment was available and although at one clinic we found the checking of this had been inconsistent it had been identified and was being addressed.

The dental service worked in partnership with other services for example the local acute hospital and referring dentists to provide coordinated and timely care to meet the needs of patients. Pain relief was well practised.

Specialised treatment was undertaken at dedicated centres with the appropriate trained staff and support systems to ensure patient safety. Staff received on-going mandatory and specialised training. New staff received an induction to ensure they were able to undertake their role safely and effectively.

The service was effective at monitoring and improving patient outcomes. A number of audits had taken place and the results had been used to improve the service. Treatment was given according to national guidance.

People were overwhelmingly positive about the care and treatment received. We saw people were involved in their care and they were given time to ask questions about any aspect of their treatment. We saw good interactions between staff and patients. People we spoke with felt their particular needs and concerns were understood and respected by staff. Staff we spoke with demonstrated they cared about their patients. We found staff to be proud and committed to providing a specialised dental service for patients.

We observed people were consulted at each stage of treatment to ensure they had their permission to proceed and that people were given reassurance before continuing. The staff were familiar with the patients fears and took time to reassure and relax the patient without the need to use medication. Staff were able to demonstrate a good understanding of how and why it was important to obtain and record consent for examination and treatment.

Patients were given clear explanations during pre-assessment avoiding the use of technical terms and providing diagrams to enhance the patients understanding of planned treatment. Patients were given different choices of treatment and the benefits of each option were carefully explained.

There were pictorial care pathways provided for children who had been assessed as requiring general anaesthetic. This was provided to help them understand what to expect and minimise their fears about planned treatment. During appointments the dentists asked questions about each patient's current oral hygiene practice and gave suggestions how this could be improved to prevent problems.

People were referred to the community dental service who had been assessed as having complex or special needs, including learning difficulties, where treatment with a general dental practitioner was not possible. Staff understood the special needs of their patients and provided a service to meet those complex needs. Most patients were seen within six to eight weeks from referral. The dental service also provided a domiciliary (home visiting) service for people who were not able to attend the clinic due to illness or disability.

There was good collaborative working between the service and other healthcare services to ensure good patient outcomes.

Summary of findings

Obtaining feedback from patients was actively promoted and we saw evidence that information was used to improve the service. We saw results of patient feedback were displayed in public areas, which showed there was a high level of satisfaction with the service provided. There were four complaints relating to dental services during 2012/13. Two of these complaints were upheld and no trends in the reasons for the complaints were identified. Staff were able to describe what actions they should take if a patient or their relative/carer made a complaint.

Staff were able to describe the aim of the service . There was clear leadership and a quality framework was used to ensure delivery of safe care and effective use of resources. There were few incidents or complaints within the dental service.

There was commitment from staff to obtain and learn from feedback from patients including the use of audits to improve the quality of the service. We saw evidence of improvement initiatives and monitoring of the quality of the service.

Staff said senior managers within the trust were supportive and responsive but they could tend to make decisions about the service without the involvement of the dental team. Staff had opportunities to meet with their line managers and team members. Arrangements for one to one supervision of staff had been put in place and staff felt valued.

Summary of findings

Background to the service

Norfolk Community Health and Care NHS Trust provided a range of specialised dental services in the community of Norfolk across a population of approximately 882,000.

The Specialist Care Dental Service included:-

- Behavioural management,
- Sedation - Inhalation and intravenous
- General Anaesthesia
- Domiciliary Care

In addition the trust provided :-

- Dental access services
- Prison dental services
- Out of Hours dental services
- Public health function

During our visit we visited three dental centres in Norfolk and attended a Domiciliary visit. We spoke with seven patients who used the service and six relatives and carers. We observed a number of patients being treated at the centres we visited, including one patient who was receiving treatment under sedation. We spoke with 15 members of staff, which included the clinical director, dental services manager, dental specialist, dentists, dental nurses, cleaning and administration staff.

Our inspection team

Our inspection team was led by:

Chair: Dorian Williams, Executive Nurse/director of Governance, Bridgewater Community Healthcare NHS Trust.

Team Leader: Carolyn Jenkinson Inspection Manager**,** Care Quality Commission

The team included CQC inspectors and a variety of specialists: Health visitor, school nurse, GP, medical consultant, nurses, specialist palliative care nurse, university lecturer, therapists, social worker, dentist, senior managers and experts by experience. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Why we carried out this inspection

Norfolk Community Health and Care NHS Trust was inspected as part of the second pilot phase of the new inspection process we are introducing for community health services. The information we held and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

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

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

The inspection team always looks at the following core services at each inspection

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.

Summary of findings

2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services
4. Community services for people receiving end-of-life care.

In addition, the inspection team also looked at community dental services.

Before visiting, we reviewed a range of information we held about Norfolk Community health and Care NHS Trust and asked other organisations to share what they knew. We carried out an announced visit on 16, 17 and 18 September. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We visited three locations where dental services were being delivered and spoke with seven patients and 6 relatives as well as 15 members of staff. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 2 October 2014 to three of the inpatient hospitals.

What people who use the provider say

We received a range of comments from patients and their relatives, both through comment cards as well as those we spoke with during the inspection. The comments were overwhelmingly positive, with patients commenting on the quality of staff, high standards of care they had received and timeliness of accessing the right care at the right time.

There is no current requirement for community trusts to adopt the Family and Friends Test (FFT), but Norfolk implemented the FFT in community services in July 2013. The FTT is a national initiative and aims to ensure patient experience remains at the heart of the NHS, so members of the public can see what patients think of local services, and that service quality is transparent to all. A simple score is generated by taking the proportion of respondents who would be 'extremely likely' to recommend the service, minus the proportion of those who say they are 'neither likely nor unlikely', 'unlikely' or 'extremely unlikely' to recommend it. Patients are then encouraged to comment on why they gave that score, enabling services to understand what really matters to them.

The national target is for 75% positive response and 15% sample size. The trust had not yet supplied sample size. Between July 2013 and March 2014 the trust reported an overall score of 79% positive responses, the lowest result being 72% in July 2013 and the highest being 86% in March 2014.

There have been 140 comments on the trust on the patient opinion website, with 128 of these being positive in nature. Of the negative reports, six were regarding staffing levels and waiting times, three were around staff attitude and three regarding poor care.

Good practice

- The care and compassion shown to patients by staff.
- The commitment of staff to the service. Staff were very proud of the care and treatment they offered.
- The ability of the service to adapt care and treatment in order to meet people's individual needs
- The provision of safe care through effective use of infection control and decontamination procedures.
- The effective use of screening services and surveys to continuously improve the service and promote dental health within the local population.
- Care was consistently based on evidence based guidance and subsequently followed good practice.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The service should ensure that emergency equipment is regularly checked to ensure it is in good working order should it be needed.
- The service should ensure that the temperature of the medicines refrigerators are checked daily and that appropriate action is taken if the temperature is outside of the required levels.
- The trust should consider developing more formal communication channels with the service to ensure they feel engaged in service development, design and commissioning.

Norfolk Community Health and Care NHS Trust

Community dental services

Detailed findings from this inspection

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

Good

Are Dentistry safe?

By safe, we mean that people are protected from abuse

Summary

There were systems and processes in place to keep people safe. Staff knew how to report incidents and there was evidence of learning from these. There were good infection prevention and control procedures in place and staff took responsibility for this. Staff demonstrated an in depth knowledge of decontamination best practice.

Equipment was serviced and was checked before use. We found the temperature checks of the medicines refrigerators were not consistently taking place but this was being addressed. Apart from drugs stored in the refrigerator, other medicines were stored safely. Staff could describe their responsibilities under safeguarding patients in their care and we found where concerns had been raised the appropriate procedures had been followed.

Records were well maintained and consent was taken prior to procedures being carried out. There were procedures in place to assess and respond to patients risks. Patients medical history was obtained and individual risks were identified. Emergency equipment was available and although at one clinic we found the checking of this had been inconsistent it had been identified and was being addressed

Incidents, reporting and learning

Staff we spoke with were aware of, and had access to, the trust's online incident reporting system. This allowed staff to report all incidents including near misses where patient safety may have been compromised. Staff we spoke with told us they received training at their induction about how to report incidents and were able to give examples of incidents they considered reportable such as needle stick injuries and medication errors. One staff member was able to give an example of a recent near miss where a child was found to try to touch a pest control device in a reception area. Staff were able to describe the actions taken by their manager to remove the risk. We saw evidence of staff inductions and that staff had access to the trusts guidance about the management and reporting of incidents. Although 318 serious incidents occurred at the trust between June 2013 and May 2014 none of these related to the dental service.

Good

Are Dentistry safe?

Cleanliness, infection control and hygiene

All the premises we visited were visibly clean. Hand washing facilities were appropriate and well stocked in each area of the clinics we visited with notices displayed to promote good hand hygiene practice. Sinks in the treatment areas had elbow operated taps and foot operated waste bins. We observed the cleaning and preparation of clinics between procedures and this included the cleaning of surfaces and applying fresh protective covers to equipment. Staff had a schedule they worked with, this included safety checks and cleaning tasks to be completed each day when the clinic opened, between treatments and when they closed the clinic. Staff told us, "We have to sign each item when we have completed it, it helps ensure nothing is missed."

There were on site designated decontamination rooms for the cleaning and sterilisation of instruments at each of the clinics we saw. In one centre several treatment rooms shared one decontamination room. We observed contaminated instruments were transported between the treatment and decontamination rooms in covered containers in line with best practice.

We spoke with staff about the arrangements for infection prevention and control and decontamination procedures. Staff explained the service was being changed and decontamination procedures were to be provided by the central sterilisation service department (CSSD) within the Trust. At one of the centres we visited the service had already changed to using the CSSD. We saw there were lined covered containers for the safe transporting of contaminated instruments to the CSSD. The new service included appropriate arrangements for the tracking and supply of adequate numbers of instruments to provide a safe and effective service to patients.

Staff were able to demonstrate and explain the procedures for cleaning and decontaminating dental instruments and equipment. Staff demonstrated an in depth knowledge of HTM 01-05 (a guidance document released by the Department of Health to promote high standards of infection prevention and control). There were process maps clearly displayed in decontamination rooms describing each stage of the decontamination process for staff to refer to. We saw all sterilised instruments were stored in sealed pouches and date stamped. There were checking systems in place to ensure supplies of sterilised instruments were in date. We saw records were maintained of all the safety checks of decontamination equipment undertaken on a daily basis to ensure equipment was effective and fit for purpose prior to use.

During both the provision of treatment and the decontamination of instruments, staff were observed to use and wear the appropriate personal protective equipment such as aprons gloves and goggles/visors. Patients were also suitably protected and provided with bibs and safety glasses to wear during treatment.

There were systems in place for the segregation and correct disposal of waste materials such as x ray solutions, amalgam and sharps. Sharps containers for the safe disposal of used needles were available in each clinical area; these were dated and were not overfilled. Staff were able to demonstrate they were in the process of changing over to the use of safety needles which retract after use and do not require re sheathing. This meant the risk of needle injuries was minimised. We saw stocks of these needles were already in place in some clinics. Notices were displayed in clinical areas explaining the actions staff should take in the event of an injury from a needle.

Maintenance of environment and equipment

Staff told us tests were undertaken to check the water for legionella although we did not see specific evidence of this during our inspection. We saw checks of fire equipment had been completed. One staff member told us, "The cleaning is monitored daily, we feel there has been a general improvement in the standard of service." There were records to show x ray equipment, sterilizers and ultrasonic cleaners had been recently tested and serviced.

Medicines management

Medicines including medical gases were stored securely. There were no daily temperature checks made of drugs stored in the drug refrigerator. This meant there was a risk that the efficacy of medicines could be altered. We spoke with the senior nurse who was able to show us evidence a thermometer had been ordered to enable staff to check medicines were stored at the correct temperature in accordance with manufacturer's recommendations. We also found a medicine that was marked to be stored in the fridge but was not.

All the medicines stored at each clinic were in date and we saw records to show these were checked weekly. At some clinics staff had developed lists of each medicine stored on

site with its expiry date to help them anticipate when replacements would be required and avoid disruption to the service. On one site there were Controlled Drugs, which are medicines that require additional security. These were observed to be managed and stored in accordance with regulatory requirements. We saw there were systems in place for the correct and safe disposal of expired or unwanted medicines. Medicine prescription pads were stored securely and there was a record maintained of their usage to allow traceability and minimise the risk of inappropriate use. Staff had access to the trusts medicines policy and British National Formulary's some of which were noted to be out of date. The out of date BNF's were brought to the attention of staff in the clinic.

Safeguarding

Each staff member we spoke with was able to describe their responsibilities in safeguarding patients in their care and they had an understanding of the different types of abuse. We saw staff had received training at induction and safeguarding was also included in staff's mandatory training in accordance with the trusts policy. Staff were able to tell us who they should report a safeguarding concern to. There were notices displayed in public areas advising people what they should do if they were aware of, or suspected abuse of someone. We saw where there had been recent safeguarding alerts raised and these had been responded to and investigated appropriately. The incidents had been well documented but staff told us they had not received feedback about the outcome.

Consent

Staff were able to demonstrate a good understanding of how and why it was important to obtain and record consent for examination and treatment. We observed a patient attending an appointment for treatment with their carer and the explanations given to them. The dentist repeated questions such as ''Are you happy for me to do the work'' and gave time for them to reply and ask questions.

The clinics had access to the different types of consent forms to be used in accordance with the trusts consent policy and we saw examples of consent forms which had been fully completed signed and dated. Patients were given a copy of their consent form.

Records systems and management

Patient's records were mostly in electronic format and access to these was via a secure password. Paper records were stored in locked cabinets to ensure confidentiality. Records included essential information such as allergies, medical history allergies and current medication being taken. They also included treatment plans and evidence of discussions with the patient or their parent/carer. Paper records contained completed consent forms and correspondence such as referral letters.

We looked at staff records and saw appropriate checks had been completed prior to employment such as checking professional registration and disclosures to ensure people were cared for by staff with the appropriate qualifications and who were fit for employment.

Assessing and responding to patient risk

For patients undergoing specialised treatment, staff we spoke with explained each patient attended a pre-assessment visit with one of the dentists to understand their medical history and identify any individual risks prior to deciding the appropriate course of treatment. Information leaflets and notices were displayed to remind people of the importance of notifying their dentist if they were taking oral anticoagulants and the associated risks. Where people were treated in their homes the dentist ensured people had written contact details about how to obtain urgent help via the out of hours service.

The dental service provided a domiciliary (home visiting) service for people who were not able to attend the clinic due to illness or disability. Each clinic we visited had a domiciliary kit that included equipment required for dental examinations and routine procedures. We saw there were checking procedures in place to ensure equipment and medicines were ready and fit for purpose, these checks were dated and signed. The kit included emergency medicines and arrangements for the safe transporting of contaminated instruments and portable oxygen.

There were emergency call bells in the treatment rooms for staff to summon assistance in an emergency. Emergency equipment was available at each site visited included oxygen, emergency medicines and defibrillators. Staff we spoke with were familiar with the equipment and we saw evidence staff had received appropriate training to respond to emergencies and use the equipment provided.

We looked at emergency equipment at the Siskin dental centre and saw checking of this equipment had been inconsistent. Staff we spoke with were unsure who was responsible for these checks. They told us, ''I suppose we

Good

Are Dentistry safe?

assume someone else has done it and the checks get missed." We raised our concern with the senior nurse who had been recently appointed. They told us they were aware of the concern and able to show evidence of the steps taken to address this. The nurse had allocated tasks such as equipment checks to specific staff members on the staff rotas for each day of the week to avoid this process being overlooked.

Staffing levels and caseload

Both the staffing levels in the service and the skills of staff were able to meet patient's needs. The dental services in the trust were meeting the Department of Health's expectation in dentistry (A review into NHS Dentistry-The Steele Review 2009).

The staff told us they felt their staffing levels were adequate.

Staff confirmed they were mostly able to meet the needs of the volume of patients using the community dental service. Dentists we spoke with expressed concerns about the recent reduced length of time allocated for appointments. The time had been reduced from 30 minutes to 20 minutes and felt it was difficult to meet the specific needs of patients referred to the specialist service.

Good

Are Dentistry effective?

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

Summary

The dental service worked in partnership with other services for example the local acute hospital and referring dentists to provide coordinated and timely care to meet the needs of patients. Pain relief was well practised.

Specialised treatment was undertaken at dedicated centres with the appropriate trained staff and support systems to ensure patient safety. Staff received ongoing mandatory and specialised training. New staff received an induction to ensure they were able to undertake their role safely and effectively.

The service was effective at monitoring and improving patient outcomes. A number of audits had taken place and the results had been used to improve the service. Treatment was given according to national guidance.

Evidence based care and treatment

Staff had undertaken an audit to monitor performance. The audit looked at the referrals received to identify if the service was being used appropriately. Treatment was in line with national guidance, for example National Institute for Health and Care Excellence (NICE), British dental Association (BDA) and General Dental Council (GDC).

Pain relief (optional)

Dentists explained the benefits and use of local anaesthesia prior to its administration and ensured patients understood what effects they may experience. We observed time was given for localised anaesthesia to take effect prior to proceeding with treatment. Inhaled or intravenous pain relief was administered according to planned treatment that had been agreed with the patient. These types of pain relief were only used where the staff had the skills and facilities to ensure patient safety. Following treatment dentists gave verbal advice about pain relief and provided information leaflets which included advice about pain relief.

Patient outcomes performance (combine with above if appropriate)

Recent audits had been undertaken regarding post-operative care and referral processes. Post-operative information for patients had been revised which had resulted in a reduction in the number of patients returning with post-operative complications. To improve referral processes the standard referral form had been revised. There were mixed responses from staff regarding its effectiveness. Some staff told us they received more patient information about patients referred for treatment as a result of the revised referral form. Other dentists reported the actual number of inappropriate referrals had not reduced as a consequence.

The dentist and staff at the Attleborough clinic explained they participated in Epidemiology studies organised by Dental Health Intelligence programme to improve patient outcomes. We saw staff had been supported and trained to use the system and participate in the national programme.

Staff undertook regular audits of clinical records and consent processes, the results of these were reported at monthly staff meetings to ensure shared learning and agree actions to improve standards of record keeping. Other previous audits had included the prescribing of antibiotics.

Competent staff

Specialised treatment was undertaken at dedicated centres with the appropriate trained staff and support systems to ensure patient safety.

We saw evidence staff received on-going mandatory and specialised training following an induction to their role on appointment. The Trust wide figures showed that 87.1% of staff had completed mandatory training. The staff we spoke with had all completed their mandatory training and we saw evidence of this.

We reviewed staff records and saw training needs had been identified and agreed at appraisal and these had been acted upon. There was evidence staff had the appropriate qualifications to safely deliver patient care. Staff were satisfied with internal and external training opportunities. Staff said, ''if there is some training we particularly want to do our manager supports us. I was able to attend a training session about the care of children under general anaesthetic.''

Good

Are Dentistry effective?

Clinical staff were registered with the General Dental Council, (GDC). The GDC is an organisation which regulates dental professionals in the UK. We saw evidence that clinical staff participated in Continuing Professional Development (CPD) in line with their GDC requirements.

The community dental service provided a range of specialised dental services to treat people with complex or special needs and vulnerable people who met their acceptance criteria. These included people who required either inhaled, intravenous sedation or general anaesthesia. We saw evidence staff had received training to provide inhalational sedation.

Use of equipment and facilities

We observed equipment was used appropriately and for the purpose it was intended. The centres had modern treatment rooms and x ray facilities. We saw records of regular maintenance and servicing of specialist equipment by the manufacturer to ensure it was fit and safe for use.

Multi-disciplinary working and coordination of care pathways

Staff worked in partnership with other specialists to ensure a patient focused service. For example, they liaised with gynaecological, ophthalmic and podiatric specialists regarding patients scheduled for treatment under General Anaesthetic (GA) to minimise the number of GA's a patient received. There was a general anaesthetic treatment pathway that meant the patient was cared for by the same dentist throughout their assessment and treatment.

Good

Are Dentistry caring?

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

Summary

People were overwhelmingly positive about the care and treatment received. We saw people were involved in their care and they were given time to ask questions about any aspect of their treatment. We saw good interactions between staff and patients. People we spoke with felt their particular needs and concerns were understood and respected by staff. Staff we spoke with demonstrated they cared about their patients. We found staff to be proud and committed to providing a specialised dental service for patients.

We observed people were consulted at each stage of treatment to ensure they had their permission to proceed and that people were given reassurance before continuing. The staff were familiar with the patients fears and took time to reassure and relax the patient without the need to use medication. Staff were able to demonstrate a good understanding of how and why it was important to obtain and record consent for examination and treatment.

Patients were given clear explanations during pre-assessment avoiding the use of technical terms and providing diagrams to enhance the patients understanding of planned treatment. Patients were given different choices of treatment and the benefits of each option were carefully explained.

There were pictorial care pathways provided for children who had been assessed as requiring general anaesthetic. This was provided to help them understand what to expect and minimise their fears about planned treatment. During appointments the dentists asked questions about each patient's current oral hygiene practice and gave suggestions how this could be improved to prevent problems.

Compassionate care

Patients and their relatives told us staff were patient and understanding. People spoke positively about the care and treatment received. One patient said, "I was so nervous I was housebound initially but over several appointments I have been able to have treatment.'' Another patient said, ''They are a very dedicated team.''

We observed good interactions between staff and patients. For example one dentist put people at their ease and chatted with patients recalling important events in their lives such as school exams, their favourite sports. One patient said, ''They talk with you first and chill you out, they give you time.''

We spoke with the parent of a child attending a pre-assessment appointment, they said, ''My child needs quite a bit of dental work and is terrified of the dentist but they have managed to gain her cooperation and been so patient with her.''

The reception staff took time with people booking appointments, they offered different options to patients and checked people understood the appointment system and if they had any other queries.

We saw correspondence from previous patients who had written to the staff to thank them. One person had written, ''Other dentists refused to listen to me, you understood and helped me, thank you so much, I cannot tell you the difference you have made to my life.''

A relative during a domiciliary visit said, '' We only needed a little bit of help. It's so difficult for me to help my wife even go to the shops. I never expected this, it's wonderful. Look she doesn't even know the tooth has been removed, he (the dentist) is amazing." One patient who had experienced difficulties attending for treatment due to problems with their wheelchair had written to the staff to thank them for understanding their situation and helping them.

Staff we spoke with demonstrated they cared about their patients. One member of staff said, ''The best thing about this job is the patients, I like to establish a rapport and have the time to do this.'' Another staff member who had been doing the job for 13 years said, ''I love my work, one of the biggest positives is being able to help people particularly children.''

Dignity and respect

We observed people were consulted at each stage of treatment to ensure they had their permission to proceed

Good

Are Dentistry caring?

and that people were given reassurance before continuing. For example, one person we spoke with had a phobia of dental treatment and told us he would gag the moment an examination commenced.

We observed the dentists ensured when discussing treatment options with people they maintained eye contact. The staff were familiar with the person's fears and took time to reassure and relax the patient without the need to use medication. People were greeted in a friendly and courteous manner and reception staff were discreet to ensure patient confidentiality when booking appointments for patients in the reception area or by telephone. During treatment doors were kept closed to ensure privacy.

Patient understanding and involvement

A patient we spoke with said, ''I have been coming here for 5 years, they (the staff) are amazing, they are always so sympathetic. They have fixed everything for me. If you are not clear you can ask them anything, they are really nice people.'' We observed patients being given clear explanations during pre- assessment avoiding the use of technical terms and providing diagrams to enhance the patients understanding of planned treatment. Patients were given different choices of treatment, the benefits of each option were carefully explained. We observed one patient being told, ''You don't actually need to have the tooth extracted.'' An explanation was given about why this was so and how the patient could prolong the life of the damaged tooth. Patients were told to raise their hand if they wanted the dentist to stop treatment and have a rest. This meant patients had an effective means of communication and control during treatment.

When people attended appointments for treatment a further discussion took place to ensure the patient recalled and understood what treatment was to be provided. Written information provided to people was seen to be up to date and checks were made by the staff that patients understood information provided.

Emotional support

We observed the dentists asked patients if they would like their relative or carer to accompany them in the treatment room. At one clinic the dentist positioned the parent of a child receiving treatment and checked the child was able to see their parent throughout their treatment. When local anaesthesia was administered the dental nurse held patients hand and gave reassurance and praise.

There were pictorial care pathways provided for children who had been assessed as requiring general anaesthetic. This was provided to help them understand what to expect and minimise their fears about planned treatment. Children showed to us they had received stickers after treatment as a reward for being a good patient.

Promotion of self-care

The dental service employed three oral health educators. We saw recent correspondence from children displayed in the reception area describing what they had learnt about caring for their teeth.

During appointments the dentists asked questions about each patient's current oral hygiene practice and gave suggestions how this could be improved to prevent problems. Where a patient's carer was attended an appointment with the patient they ensured the carer was involved in the discussion. People who had received treatment were given explanations about what to do to minimise discomfort and prevent problems such as having saline mouthwashes following dental extractions. The dental nurses ensured patients also received written information about how to care for their teeth after treatment and between appointments. The staff went through the information to ensure they understood it.

Good

Are Dentistry responsive to people's needs?

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

Summary

People were referred to the community dental service who had been assessed as having complex or special needs, including learning difficulties, where treatment with a general dental practitioner was not possible. Staff understood the special needs of its patients and provided a service to meet those complex needs. Most patients were seen within six to eight weeks from referral. The dental service also provided a domiciliary (home visiting) service for people who were not able to attend the clinic due to illness or disability.

There was good collaborative working between the service and other healthcare services to ensure good patient outcomes.

Obtaining feedback from patients was actively promoted and we saw evidence that information was used to improve the service. We saw results of patient feedback were displayed in public areas, which showed there was a high level of satisfaction with the service provided. There were four complaints relating to dental services during 2012/13. Two of these complaints were upheld and no trends in the reasons for the complaints were identified. Staff were able to describe what actions they should take if a patient or their relative/carer made a complaint.

We saw the staff had access to an interpreting service.

Service planning and delivery to meet the needs of different people

People were referred to the community dental service who had been assessed as having complex or special needs, including learning difficulties, where treatment with a general dental practitioner was not possible. The service also met the needs of children under 16 years of age with behavioural or management problems which made them unsuitable for treatment within general dental services. Staff reported most patients were seen within six to eight weeks from referral. Staff anticipated this waiting time would improve when new staff recently recruited had commenced.

The service worked collaboratively with other services such as general dental practitioners, social workers and hospital teams. Dentists and surgeons worked collaboratively, for example for those patients whose medical condition necessitates dental care being undertaken in a hospital setting. This meant patients received care in the environment that could safely meet their needs. Appointments were timed to allow people with more complex needs the time they needed.

The dental service provided a domiciliary (home visiting) service for people who were not able to attend the clinic due to illness or disability. The relative of one patient we visited said, I don't know how we would have managed without this visit it's so difficult to get out, they (the staff) are wonderful."

The centres had adequate waiting facilities to meet the needs of adults and children. The centres we visited all had wheelchair access and accessible toilets.

Access to the right care at the right time

We observed staff made every effort to accommodate people's needs when planning appointments. The service had arrangements to accommodate patients who needed to be seen urgently. There were two dental access centres, one in Kings Lynn which included an out of hour's service and one at Siskin Dental centre. The dental access centres provided urgent dental treatment to those patients who had been unable to obtain urgent treatment in a general dental setting. The service could be accessed by self-referral or referral by other health professionals. We saw information was displayed and provided on the opening hours of the practice and how to access the 'Out of Hours' service.

Discharge, referral and transition arrangements

Staff explained patients were reviewed at the end of a course of treatment before being discharged back to general dental services. On completion of treatment patients were discharged into the care of general dentistry unless the severity or complexity of their condition required their on-going care to continue within the specialised service. Where patients continued to meet the acceptance criteria for the specialised service they were advised recall appointments would be offered at appropriate intervals in accordance with National Institute of Clinical Excellence (NICE) guidelines.

Good

Are Dentistry responsive to people's needs?

Complaints handling (for this service) and learning from feedback

There was a leaflet entitled, "Patient Experience – Dental Services" available to patients in the clinic reception areas. Questions asked included 'Did the staff treat you with respect and dignity?, Were you given enough information to help you decide about your care? This meant the service could evaluate if their actions to protect people's privacy and dignity and provide information were effective. We saw results of patient feedback were displayed in public areas, which showed there was a high level of satisfaction with the service provided. Patient's letters, including those from children about the care they had received were displayed in the reception areas and the comments were positive.

We heard staff actively encouraging patients to complete the feedback forms, saying ''We need to know if we are getting it right."' The Practice information leaflet included information about how people could report a concern or make a complaint and directed them to more detailed information available as a separate leaflet titled 'Comments, Complaints, Compliments.' The information was available in different formats such as large print audio and braille to meet patient's different needs.

There were 170 complaints received by the trust during 2012/13. Four of these complaints related to dental services of which two were upheld. There were no trends identified. Staff were able to describe what actions they should take if a patient or their relative/carer made a complaint. The actions described reflected the Trusts policy on complaints management. Staff said, ''We try to make the person feel important and that their concern will be taken seriously.'' They told us they would notify their line manager and document what the patient had reported to them.

Staff told us they often treated people who required a language interpreter. We saw the staff had access to interpreters by phone and some interpreters were available to attend appointments so the patients was given an interpretation of the planned treatment and care. Staff explained access to this service was particularly important when obtaining consent for receiving a general anaesthetic. We did not see any records to show how often the interpreting service was used, although staff did appear knowledgeable about the policy and process for obtaining the service.

Good

Are Dentistry 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

Staff were able to describe the aim of the service . There was clear leadership and a quality framework was used to ensure delivery of safe care and effective use of resources. There were few incidents or complaints within the dental service.

There was commitment from staff to obtain and learn from feedback from patients including the use of audits to improve the quality of the service. We saw evidence of improvement initiatives and monitoring of the quality of the service.

Staff said senior managers within the trust were supportive and responsive but they could tend to make decisions about the service without the involvement of the dental team.

Staff had opportunities to meet with their line managers and team members. Arrangements for one to one supervision of staff had been put in place and staff felt valued.

Vision and strategy for this service

Staff were able to describe the aim of the service which was to complement general dental practice by providing specialised services for those patients with complex or special needs, vulnerable people and those who cannot obtain general dental services because of those needs. They explained that people were usually referred back to general dentistry after treatment except those people with severe or complex medical conditions which meant they continued to receive on going care within the service.

There was a trust wide Quality Improvement Strategy in place which set out the trusts vision and approach to quality for 1014-2016. We did not see any specific strategy in place for the dental service.

There was an Organisational Development Strategy in place that was developed from engagement of staff across the trust . As part of this work the trust values have been refreshed involving 900 staff members and were formally signed off at an extraordinary Board on in June 2014. The values were in the process of being rolled out across the trust through promotion materials, training at Induction, mandatory training and leadership training. We found some staff knew about the values.

Governance, risk management and quality measurement

We saw examples of service improvement initiatives such as working to reduce post treatment complications through revising the written after care information patients received. We saw a number of different audits developed by the dental team but it was unclear how this information fed into the trusts overall quality framework.

There were few incidents or complaints within the dental service. We saw there was a governance structure which included sub committees such as Infection Control, Clinical Audit & Effectiveness, Risk and Water management. Any issues such as incidents or infections relating to dental services were reported into the trusts Quality and Risk Assurance Committee from the sub committees to enable the overall identification of trends and ensure lessons were learned.

Leadership of this service

Staff generally spoke well of senior management within the trust and the dental service. Staff said they were supportive and responsive but that senior managers could tend to make decisions about the service without the involvement of the dental team. One staff member said, ‘’We tend to feel left out at times and are not consulted when we should be.’’

Staff told us they felt all of the team were approachable and the clinical leaders had an open door policy.

A new senior nurse had recently been appointed. The nurse demonstrated the qualities of a strong and capable leader.

Culture within this service

Staff we spoke with spoke proudly of the service and were committed to ensuring patients received a compassionate and high quality of care. During our inspection we observed this passion and commitment translated into the

Good

Are Dentistry well-led?

actual delivery of care. Patients we spoke with were keen to tell us how impressed they were by the service provided; in particular they mentioned the understanding and patience of staff to ensure their needs were met.

Staff told us they had opportunities to meet with their managers and team members. Staff said, they (the managers) were very supportive and listen to what we have to say. They described how they felt valued and supported to develop their skills to enhance the service provided. Staff explained one to one meetings at regular intervals were to be introduced and felt this was a useful innovation.

We saw the results of the trusts staff survey for 2013. The results for indicators such as staff motivation, job satisfaction and ability to contribute towards improvements reflected the findings of our inspection to this service.

We found the staff to be patient focused and provided patient centred care.

Public and staff engagement

The trust held a Recognition of Excellence and Achievement in Community Health (REACH) ceremony on an annual basis. This is an awards ceremony to recognise the contribution of staff. In March 2014 the awards included some for staff working in inpatient areas including the specialist neurological rehabilitation inpatient service.

Every month the trust board heard about a patient's experience at the start of their board meeting. A patient or carer is supported by the Patient Experience and Involvement team to share their experiences of their care from the trust and how this connected with other services they may have experienced. Patients and carers can directly tell the board about where care has been good and where improvements can be made. Actions arising are followed up by the Director of Nursing Quality and Operations.

The results of the 2013 NHS Staff Survey showed the trust has performed better than the national average against five questions and worse than the national average against three questions. The trust performed better against questions regarding staff feeling their role made a difference to patients, effective team working, staff receiving job-relevant training, staff being appraised and staff receiving health and safety training. The trust performed worse than average against five questions – the percentage of staff experiencing physical violence from patients, staff experiencing harassment from staff, staff feeling under pressure to work when unwell, staff reporting good communication with management and staff recommending the trust as a place to work. The trust's performance has deteriorated against the first two questions.

Innovation, improvement and sustainability

The dental services carried out epidemiological surveys using national standards and criteria set by the Department of Health to provide information to inform planning of dental services regionally and nationally.

Screening of local populations was undertaken where there was evidence needs were unmet to improve oral health and find the most effective way of meeting those needs. We saw evidence of oral health promotion activities including those at schools and children's centres and feedback from children about what they had learnt.