

Locala Community Partnerships C.I.C.

1-256729774

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)
1-285685717	Beckside Court	Community dental services	WF17 5PW
1-285685937	Holme Valley Memorial Hospital	Community dental services	HD9 3TS
1-285685809	Cleckheaton Health Centre	Community dental services	BD19 5AP
1-285685765	Batley Health Centre	Community dental services	WF17 5ED
1-58466529	Dewsbury and District Hospital	Community dental services	WF13 4HS
1-285686345	St John Health Centre	Community dental services	HX1 5NB

This report describes our judgement of the quality of care provided within this core service by Locala Community Partnerships C.I.C. 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 Locala Community Partnerships C.I.C and these are brought together to inform our overall judgement of Locala Community Partnerships C.I.C

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall, we rated this service as good because:

- Dental services were effective and focused on the needs of patients and their oral healthcare. We observed examples of clinicians and teams working together effectively in the service. The service was reviewing its referral system and integrating a triage process to ensure patients received care by the appropriate clinician and at a clinic that met their needs.
- Systems for identifying, investigating and learning from patient safety incidents were in place. There was evidence that lessons learnt from incidents and complaints were shared across the teams.
- Infection control procedures were in place and audits had been carried out. The environment and equipment were clean and well maintained.
- Staff told us they felt supported by their managers, they were informed of the future strategy of the service and had the opportunity to participate in the planning. There were governance systems in place.
- The focus of staff was to provide a positive and caring environment, where patients were at the centre of all they do.

- Patients told us they had positive experiences of care at each of the clinics we visited. Patients, families and carers felt well supported and involved with their treatment plans and staff displayed compassion, kindness and respect at all times. We saw examples of staff caring for families and not just the patient. Patients and their families were appropriately involved in and central to making decisions about their care and the support needed. Staff used imaginative ways to engage younger patients in care.

However:

- The service provided treatment in a hospital setting under general anaesthetic to children, but did not provide paediatric nursing staff to support children's recovery from anaesthetic in the recovery area in all of the hospital settings. This is recommended by the Royal College of Nursing (2013) to ensure safe paediatric care.
- Staff are required to undertake level two safeguarding children training, however overall only 19% had received this training as of August 2016. The organisation had a trajectory to achieve 100% compliance by 31 March 2017.

Summary of findings

Background to the service

Locala Community Partnerships CIC provided dental care for vulnerable groups and people with complex special care needs, both for adults and children, who due to their circumstances would find it difficult to access general dental practice services.

The service was provided in seven clinical sites across Calderdale and Huddersfield, and also as a domiciliary service in care homes, schools and patients' own homes.

General anaesthetic procedures were delivered at Dewsbury District Hospital, in partnership with Mid Yorkshire Hospitals NHS Trust and at Huddersfield Royal Infirmary, in partnership with Calderdale and Huddersfield NHS Foundation Trust.

During our inspection we visited clinics at the following health centres:

- Batley Health Centre
- Cleckheaton Health Centre
- St John's Health Centre
- Holme Valley Memorial Hospital
- Princess Royal Community Health Centre

We also attended a theatre list at Dewsbury District Hospital.

During the inspection we spoke with 14 staff and six patients. We looked at 15 dental records across the service. We reviewed information about the provider and data provided by the service.

Our inspection team

Our inspection team was led by:

Chair: Carole Panteli, Director of Nursing (retired)

Team Leader: Berry Rose, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a safeguarding specialist, a

governance specialist, professional lead nurse for children's integrated therapy and nursing service, district nurses, a community matron and an occupational therapist. Additionally, there was an expert by experience who had experience of community health services.

Why we carried out this inspection

We inspected the following community health services as part of our comprehensive community health services inspection programme:

- Community adults services (including end of life care)

- Community inpatient services
- Community dental services
- Community services for children, young people and families

How we carried out this inspection

Locala Community Partnerships CIC provides a range of primary care and community services. These are GP services, community health services (as listed below), sexual health services and primary dental care. We didn't

inspect all of these services in October and November 2016. In October and November 2016 we inspected the following community health services provided by Locala Community Partnerships CIC:

- Community adults services (including end of life care)
- Community inpatient services
- Community dental services

Summary of findings

- Community services for children, young people and families

We have not rated Locala Community Partnerships CIC as a provider for each of the five key questions or given an overall rating because we did not inspect how well-led the organisation was in relation to all the services that it provides.

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 four community health core services that we inspected and asked other organisations to share what they knew. We carried out an announced visit from 11 to 14 October 2016. We carried out unannounced visits on 27 and 28 October 2016 and 4 November 2016. During the announced inspection we held focus groups with a range of staff who worked within services we inspected including nurses, therapists, doctors and support staff. We also interviewed senior staff in each of the core services we inspected and executives. We talked with people who use the services. We observed how people were being cared for, talked with carers and/or family members, and reviewed care or treatment records of people who used the services.

What people who use the provider say

We spoke with six patients who used the service. All provided positive comments about the service. One patient rated the service as 'perfect'.

Friends and family test results showed high levels of respondents would recommend the services.

Areas for improvement

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

Action the provider **MUST** take to improve

- Ensure that at all times there are sufficient numbers of suitably skilled, qualified and experienced staff, taking into account patients' dependency levels.
- Ensure that all staff have completed mandatory training and role specific training.
- Ensure that infection prevention and control policies and procedures are reviewed and in date.
- Ensure that the infection prevention and control audit programme is followed and actions are identified and implemented in a timely manner when issues are identified through the audit programme.
- Ensure that there are in operation effective governance, reporting and assurance mechanisms.

- Ensure that there are in operation effective risk management systems so that risks can be identified, assessed, escalated and managed.
- The provider must have systems in place, such as regular audits of the services provided, to monitor and improve the quality of the service.
- Ensure that staff have undertaken safeguarding training at the appropriate levels for their role.

Action the provider **SHOULD** take to improve

- Ensure that discussions relating to treatment choice and costings is documented in patient records.
- Undertake an audit of the decontamination process for assurance.

Locala Community Partnerships C.I.C.

Community dental services

Detailed findings from this inspection

Requires improvement 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- The service provided treatment in a hospital setting under general anaesthetic to children, but did not provide paediatric nursing staff to support children's recovery from anaesthetic. This is recommended by the Royal College of Nursing (2013) to ensure safe paediatric care.
- Staff are required to undertake level two safeguarding children training, however overall only 19% had received this training as of August 2016.
- A review of records showed that dentists did not always document their discussions with the patient about treatment options available to them, their decisions about treatment and treatment costs. These issues were highlighted in the July 2016 audit of records as requiring action.
- Audits to measure the quality of the external decontamination service were not undertaken.

However:

- There were examples of investigating incidents and sharing the lessons learnt.

- Equipment and medicines to respond to a medical emergency were available in all clinic areas. There was consistency in the checking and recording of all emergency equipment and medicines across the clinics.
- Regulations for X-ray procedures were adhered to.
- Staffing levels and skill mix were good across the clinics.

Incident reporting, learning and improvement

- Within the last 12 months there had been no never events reported. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The service used an electronic reporting system to document incidents. Between September 2015 and August 2016, 16 incidents were reported. Incidents were graded, 50% of incidents were classed as minimal and 50% as moderate. Staff knew how to report incidents, and those staff who had reported received feedback about the incident.
- In one incident a root cause analysis investigation took place which identified areas for learning. Staff were aware of this incident and were able to tell us about changes in practice, such as checking flags on patient

Are services safe?

records, and a change to the guidelines related to the care being provided which led to the incident. Learning about incidents which occurred in the service, or across the organisation, were shared through emails and staff meetings.

Duty of Candour

- Staff had knowledge of duty of candour and spoke about the need to be open and honest with patients and their carers. The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Managers were aware of their role in meeting the obligations of duty of candour. We were provided with an example where this was implemented by the managers.

Safeguarding

- Data provided showed 100% of dental services staff had completed adult safeguarding training.
- However, only 33% of clinical staff and 26% of dentists had level 2 safeguarding children training. As of August 2016, the overall training rate for safeguarding children level 2 was 19%. According to the Royal College of Paediatrics and Child Health intercollegiate document, health professionals who have regular contact with children should have level 2 safeguarding training. The organisation had a trajectory to achieve 100% compliance by 31 March 2017.
- Staff were aware of how to make a safeguarding referral and had links with the provider's safeguarding lead.
- Some staff had knowledge of safeguarding issues such as child sexual exploitation and female genital mutilation.
- Staff understood how poor dental health could be linked to neglect and communicated with GPs, school nurses and health visitors if they had concerns about a child. Records were marked if there were safeguarding concerns and information was shared if patients with a safeguarding marker did not attend an appointment.
- The provider had a current safeguarding children policy; however, the safeguarding adults policy was out of date.

Medicines

- Emergency medicines were in date and stored securely, with emergency oxygen, in a central location known to all staff. A checklist 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.
- Emergency medicines were stored together in a pack. Each clinic had two packs so that there was one to take out on domiciliary visits. The staff would remove the medicine midazolam from the pack prior to taking out of the surgery. Staff told us the rationale for this was that midazolam was a controlled drug and could not be transported. We requested information about risk assessing treating patients at home without a complete emergency drugs pack. This information was not provided to us. .
- All emergency drugs were stored in the emergency packs. Room temperatures were recorded and documented on a daily basis. If room temperatures were above 25 degrees, the expiry dates of the drugs were reduced using the Q10 calculations (a factor by which rate changes can be measured). Drugs normally kept in a fridge had their expiry dates reduced by 18 months from purchase date, to reflect being kept at room temperatures. We received confirmation from a pharmacy expert that this was safe practice.
- Each clinic had a prescription pad in use, this was stored securely.

Environment and equipment

- The clinics were located in NHS properties. Four of the clinics we visited were new buildings and in a good state of repair, or in buildings which were refurbished to a good standard.
- However, the facilities at Princess Royal Community Health Centre were in need of renovation. The treatment rooms were small which made treating patients in wheelchairs, for example, difficult for staff due to lack of space. Staff working in this clinic had accessed occupational health services due to back pain. Staff in this location also reported delays in getting repairs done to ensure the staff could provide a safe service, for example, replacing lights and fixing water leaks.
- All the clinics were secure, and had reception facilities.

Are services safe?

- The service provided hoist facilities, wheelchair tippers and bariatric equipment at clinics across the service. Patients requiring this equipment would be given an appointment at a centre where it was available.
- There were sufficient numbers of all classes of dental equipment to treat each patient attending a clinic with clean instruments; this was demonstrated when we observed drawers and cupboards appropriate for the storage of processed instruments and consumable materials. We saw evidence of this at each of the locations we visited.
- At each clinic 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 UK and British National Formulary (BNF) guidelines.
- At each clinic we visited, we were shown a well-maintained radiation protection file. This contained all the necessary documentation to ensure maintenance of the X-ray equipment and the responsible staff. A copy of the local rules was displayed with each X-ray set. This ensured that the service was acting in accordance with national radiological guidelines.
- We saw reports from a local hospital trust's radiation physics department that X-ray equipment across the service was safe for use.
- All clinic areas were clean and well organised. There was consistency across all the clinics in regards to the daily checking and recording of checks of equipment and medicines.
- Staff knew how to report faulty equipment and the process for ordering new stock or drugs.
- Equipment had been portable appliance tested.

Quality of records

- The service used an electronic record keeping system, which all staff used. There were also some paper records in use for patients who had used the service prior to the electronic system being in use, and for patients undergoing a general anaesthetic. The service was in the process of scanning all paper records onto the electronic system. The paper records used for general anaesthetic treatment were scanned onto the electronic system at the end of care.
- We looked at 15 records across the locations. Records were of a good standard and included details of examinations, consent and treatment plans. However, in

the random selection of records it was noted that one dentist did not document their discussions with the patient about treatment options available to them and their decisions about treatment. We also noted that in two records, a dentist had not documented the discussion with patients about treatment costs. This was reported to senior staff at the time of inspection. These issues were highlighted in the July 2016 audit of records as requiring action.

- The service had purchased a digital X-ray machine for each clinic. The aim was to establish a fully electronic system of records to enhance referrals to other specialists and to promote cross working across the clinics. However, after 12 months the service were still trying to find a suitable software platform for the digital X-ray machines to be compatible with the electronic record system in use.
- Records were audited across the service and action plans were in place for improvements to be made. For example, highlighting to staff the need to document consent.

Cleanliness, infection control and hygiene

- The service used an external company for the decontamination of equipment to meet HTM 01 01 (guidelines for decontamination and infection control in acute care) Essential Quality Requirements for infection control. However, no audits were undertaken within the service to measure the quality of the decontamination service, for example if instruments were returned dirty or damaged, or if there were any delays in the process. Also, we raised concerns that equipment was not kept moist during the period of collection, as according to HTM 01 01 best practice. Senior staff acted on this at the time of inspection, and raised the issue with the external company for clarification.
- Hand washing facilities and alcohol hand gel were available throughout the clinic areas.
- We observed staff following hand hygiene and 'bare below the elbow' guidance. Staff wore personal protective equipment, such as gloves and aprons, whilst delivering care and treatment. We observed appropriate disposal of personal protective equipment.
- There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps. Safer sharps use and disposal was in accordance with the EU Directive for the safer use of sharps.

Are services safe?

- Cleaning schedules were in place and displayed for each individual treatment room. These were complete and signed by the responsible dental nurse.
- We saw infection control audits completed for all clinic areas. Audit outcomes ranged from 95% to 89%; however, there were no action plans with the audits.
- At each clinic we visited, there was a range of equipment to enable staff to respond to a medical emergency, in both adults and children. This included an Automated External Defibrillator, emergency medicines and oxygen. This was in line with the Resuscitation 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. This ensured that the risk to patients' during dental procedures was reduced and patients were treated in a safe way.

Mandatory training

- Mandatory training levels as at end of August 2016 were provided for the dental service. Mandatory training consisted of 15 modules, a mix of face to face and e-learning. Safeguarding adults training was the best attended with 100% of dental staff completing it, and safeguarding children training had the lowest completion rate of 19%.
- Completion rates for the other modules of training varied from 48% to 98%. The organisation's target for mandatory training completion was 100% by 31 March 2017.

Assessing and responding to patient risk

- At Dewsbury District Hospital, where patients underwent a general anaesthetic prior to treatment, there was the appropriate medical equipment available to respond to a medical emergency. At the paediatric theatre list we attended, there was a paediatric anaesthetist and an operating department practitioner, who had training in paediatric life support. They undertook the first stage of recovery after surgery. We were told this mitigated the risk of patients not having the care of a paediatric nurse during the recovery period from the anaesthetic. This mitigation was evidenced in the risk assessment document undertaken by the organisation on 4 October 2016, in which the risk to children was rated as low. However, according to the Royal College of Nursing guidelines (2013) 'at all times there should be a minimum of one registered children's nurse on duty in recovery areas' (p16). During the period October 2015 to October 2016, 447 children received dental treatment under a general anaesthetic at Dewsbury District Hospital.
- Paediatric nurses were present at the dental theatre list undertaken in partnership with Calderdale and Huddersfield NHS Foundation Trust.
- The service used a safer surgery checklist on all patients having teeth removed. We saw this in use during the theatre list.

Staffing levels and caseload

- There were sufficient staff to meet the needs of the service. Staff worked across the dental clinics to ensure clinics had appropriate staff grades and cover to meet the needs of patients.
- There were two whole time equivalent dentists, 3.5 whole time equivalent specialist dentists, plus a whole time equivalent dentist providing clinical director leadership.
- A principle dental nurse provided leadership across the service for the 23.7 whole time equivalent dental nurses, 3.2 whole time equivalent therapists, 0.8 whole time equivalent hygienist and 3 whole time equivalent administration staff.
- The service had a vacancy of 0.6 whole time equivalent for a dentist. There were no other vacancies at the time of inspection.
- Agency staff use was 1.4%.
- Sickness levels were variable, ranging from 0.4% to 9% over the 12 months prior to inspection.

Managing anticipated risks

- Staff trained to take part in inhalation sedation undertook intermediate life support training, in accordance with Royal College of Surgeons and Royal College of Anaesthetists (2015) guidelines. The records we looked at showed evidence of safe care when delivering inhalation sedation.
- The service had a named Radiation Protection Adviser and two Radiation Protection Supervisors across the service. These individuals were appointed to provide advice and assurance that the service was complying with legal obligations under IRR 99 and IRMER 2000 radiation regulations. This included the periodic examination and testing of all radiation equipment, risk assessment, contingency plans, staff training, and the

Are services safe?

quality assurance programme. The services' named Radiation Protection Supervisor ensured that compliance with Ionising Radiation Regulations 99 and IRMER 2000 regulations was maintained.

- Staff who went on domiciliary visits undertook a risk assessment prior to the visit and updated the

assessment following the visit, to ensure staff and patient safety. This was recorded in patient notes. Staff attended domiciliary visits in pairs which overcame lone worker issues.

Are services effective?

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

Summary

We rated effective as good because:

- Treatment was evidence based and focused on the needs of the patients. There were national and local policies accessible to staff.
- The service had responded to audit data and reduced the 'did not attend' rates.
- Staff who were registered with the General Dental Council undertook continuing professional development and met the requirements of their professional registration.
- There was evidence that consent was given appropriate consideration for each patient and documented. Staff had received mental capacity training.

However:

- The service provided evidence that audits of treatment plans were undertaken, but there were no action plans in place to address the outcomes of these audits.
- The policy for consent to treatment was not dated.

Evidence based care and treatment

- NICE and clinical guidelines were accessible to all staff on the provider's intranet. Policies and procedures we saw were up to date.
- General anaesthetic procedures were in line with Royal College of Anaesthetics guidelines.
- NICE guidelines were followed, for example the dental recall intervals of patients was documented by the dentist.
- Staff demonstrated good knowledge and practice of NICE guidelines.
- We saw local policies and guidelines, which were up to date and accessible to staff.
- Audits of treatment plans were undertaken twice yearly to evaluate choice of treatment. We did not see evidence of action plans in place to address the outcomes of these audits.

Pain relief

- Patients were appropriately prescribed local and general anaesthesia for the relief of pain during dental procedures. Patients were provided pain relief through inhalation sedation or general anaesthetic when clinically appropriate.
- During treatment, we observed the clinician ask the patient if they had any pain in their teeth or mouth.

Nutrition and hydration

- Children having procedures under general anaesthetic were advised to not eat for six hours before surgery but were able to have sips of water up to two hours before surgery. This was checked by the dentist before treatment.
- Staff provided advice to patients and parents about healthy diets and reducing foods that caused tooth decay. Diet records were provided to monitor patient's intake between appointments as a way to promote health.

Patient outcomes

- Preventive care across the service was delivered using the Delivering Better Oral Health Toolkit (NICE, 2013).
- The service was part of NHS England's programme in collecting epidemiological evidence about the oral health of the local community.
- The service reported to NHS England the units of dental activity which measured the level at which the service met targets set by NHS England. The most recent report submitted was for the period April 2015 to March 2016. The report showed the service to have met and over-achieved its dental activity target for the period.
- Audits within the service were undertaken, for example treatment plans, infection control and 'did not attend' rates. The service implemented actions following the 'did not attend' audit which resulted in a 44% decrease in the rates of patients not showing up for appointments. However, for the other audits it was not

Are services effective?

clear from the audit reports what actions were being undertaken to improve patient outcomes. This suggested a lack of consistency in the way audits were managed.

- ‘Did not attend’ rates were audited. This had led to a change in the service engagement with patients to reduce the number of patients failing to attend appointments. Staff would contact patients two days before the appointment and there was also a text message sent on the day of the appointment to remind patients. The audit showed that since the introduction of these measures, did not attend rates had reduced across all clinics by 44%. Repeat non-attenders were discharged in line with the services guidelines.

Competent staff

- The service provided its own simulation training on basic life support and responding to medical emergencies for staff. Staff were also trained in clinical holding, a method of safely holding patients when having treatment to ensure they come to no harm.
- All staff we spoke with had received an appraisal in the last 12 months from their line manager and reported they received regular one to one meetings.
- Dental staff are required to undertake continuous professional development by the British Dental Association. We saw evidence from the clinical director that this was undertaken.
- Staff told us they were supported in keeping up to date with professional development and there were opportunities in the organisation for staff to access a range of course and events.
- Some dental nurse staff had additional training, for example, dental radiography, fluoride varnish applications and oral health promotion.

Multi-disciplinary working and coordinated care pathways

- There was effective and collaborative working across disciplines involved in patients’ care and treatment. For example, the dentist consulted with the patient’s GP, consultant physician or surgeon, if patients had complex medical conditions.
- The service had close working relationships with the school nursing service and health visiting teams.

Referral, transfer, discharge and transition

- There was a referral process in place to refer patients to the service. At the time of inspection, this was under review to ensure the service received appropriate referrals from general dental practitioners. The service had a triage system in place to ensure patients were seen at the appropriate time, by the most appropriate staff and in the best place according to their needs.
- Patients who were seen for single courses of treatment for sedation services or general anaesthesia were discharged back to their referring general dental practitioner. A discharge letter was provided and recorded in patient notes.
- There was no transition service as both children and adults were treated by the community dental team.

Access to information

- The electronic patient record allowed the dental team to access patients’ dental records across all of the clinics.
- All but one of the clinics we visited displayed information about the NHS charges for the treatment patients may receive and there was dental health promotion information in all clinic areas.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The service had a consent to examination and treatment policy, however this was not dated.
- There was a system for obtaining consent for patients undergoing general anaesthesia, inhalation sedation and routine dental treatment. We saw evidence of consent in the records we looked at.
- 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.
- Staff we spoke with understood the legal requirements of the Mental Capacity Act. Staff also had understanding of when it would be appropriate to apply Fraser guidelines and assess Gillick competencies, when caring for children.

Are services effective?

- Mental capacity was part of the mandatory training programme, and 98% of staff had received the training as of August 2016.

Are services caring?

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

Summary

We rated caring as good because:

- Patients told us they had positive experiences of care at each of the clinics we visited. Patients, families and carers felt well supported and involved with their treatment plans and staff displayed compassion, kindness and respect at all times.
- We saw examples of staff caring for families and not just the patient.
- Patients and their families were appropriately involved in and central to making decisions about their care and the support needed. Staff used imaginative ways to engage younger patients in care.

Compassionate care

- During our inspection, we spoke with five patients and families to gain an understanding of their experiences of care. They said they were happy with the care and support provided by the staff. We observed staff treating patients with dignity and respect. One patient described the service as 'perfect'.
- We heard staff using language that was appropriate to patients' age or level of understanding.
- Staff were considerate of people's anxieties, provided them with reassurance, and gave clear explanations about the treatment. They allowed the patient time to respond if they were not happy or in pain. We saw an example of a patient receiving treatment, who was using the service because of their anxiety.
- During care for children undergoing a general anaesthetic, we saw staff care for the needs of the parents, providing them with reassurance and support.
- We saw an example of an elderly patient being offered refreshment, and staff ensuring they were comfortable, as they had been waiting a long time for their appointment, due to a medical emergency.
- Friends and family test results for April 2016 showed 88% of patients being extremely likely to recommend

the service, from 15 responses. In June, the rate was 72%, from 28 responses. During August 2016, this had increased to a 100% response for patients recommending the service, however, there were only 3 respondents for that period. There was no data for July 2016.

Understanding and involvement of patients and those close to them

- Patients and their families were appropriately involved in and central to making decisions about their care and the support needed.
- We saw good examples of how children were involved in the treatment depending on their age. One member of the dental team used simple magic tricks to help children relax and engage in treatment.
- Staff provided parents with a range of advice to help them improve their child's dental health.
- We saw an example of meeting the needs of older people by involving their carer.
- Sensory equipment was available for patients with learning disabilities.
- Staff were able to provide support and care to patients due to having more time to spend with patients and explain treatments in detail and reduce their fear and anxieties. One member of the dental team was qualified in cognitive behaviour therapy. They used this technique for patients with phobias or who were highly anxious to successfully undertake dental treatments.

Emotional support

- Staff understood the importance of emotional support needed when delivering care. We saw staff interact in a supportive way with patients who were anxious and upset.
- We observed positive interactions between staff and patients, where staff knew the patients very well they had built up a good rapport.

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- The service was reviewing its referral system and integrating a triage process to ensure patients received care by the appropriate clinician and at a clinic that met their needs.
- Staff had received extra training to meet the needs of patients.
- Complaints were dealt with in a timely way and learning from complaints was part of governance meetings.

However:

- The service did not have access to information leaflets, to support the needs of patients whose first language was not English.

Planning and delivering services which meet people's needs

- The dental service was commissioned by NHS England. The service was in the process of developing a bid to continue to provide care in the area. This included a review of the service looking at the cost and clinical effectiveness of the service
- Referrals to the service were made by general dental practitioners and health professionals to meet the needs of people who could not use the general dental service. For example, children with high levels of dental problems and people with mental, physical and social issues. However, the referral system was being reviewed to ensure the right patients were being referred to the service to reduce waiting times for those most in need of the service.

Equality and diversity

- Some staff had received Makaton training and told us how they had used this to communicate with patients who had special needs.
- The service had access to a translation service for patients and families whose first language was not English. However, the service did not have access to leaflets and health promotion materials in languages other than English.

Meeting the needs of people in vulnerable circumstances

- Staff told us how they involved carers in meeting the needs of patients with dementia to ensure they had the correct medical information about a patient.
- The service provided hoist facilities, wheelchair tippers and bariatric equipment at clinics across the service.
- The service provided domiciliary care for people who may have difficulty accessing clinics, for example, those with a physical or learning disability, or with mental health needs.

Access to the right care at the right time

- Referrals were triaged by a dentist to ensure patients received care at the right time, by the right clinician and in the right place. For example, patients requiring bariatric equipment would be offered an appointment at either St John's clinic or Holme Valley Memorial Hospital, where the specialist equipment was based.
- Waiting times for the service were not routinely reported on, other than the waiting times for treatment under general anaesthetic. However, the service monitored waiting times for clinic patients. During April to August 2016, 12 patients had been waiting longer than 18 weeks for treatment. The delays were due to changes and cancellations to appointments.
- Staff worked across all the clinics to fill gaps which may occur during holidays or due to staff sickness.
- Referral systems were in place, for example to external services such as maxillofacial specialists.
- Processes were in place for discharge following general anaesthetic, or inhalation sedation. We were assured that patients were discharged in an appropriate, safe and timely manner. Dental nurses provided the patient or responsible adult a set of written post-operative instructions, following verbal instructions. They were also given contact details if they required urgent advice and or treatment.
- On completion of treatment, patients were discharged to the patient's own dentist for ongoing dental care.

Are services responsive to people's needs?

Learning from complaints and concerns

- Between 1st July 2015 and 12th July 2016, the dental service received seven complaints. Themes for complaints were about access and care and treatment.
- Complaints were a standing agenda item at the dental management team meetings and staff were aware of the nature of complaints.
- Information on how to make complaints were available in clinic waiting rooms.

Are services well-led?

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

Summary

We rated well-led as good because:

- The service had a strategy and vision to develop a service to meet the needs of the community, wider geographical area and their contractual obligations to NHS England.
- Staff were aware of the organisational values, and their aim was to demonstrate those values in the care they provided.
- Staff felt valued by their managers and supported in professional development.
- The service provided a social media platform for service users to engage and contribute.

However:

- The risk register did not clearly identify ways in which the service was managing and mitigating risks.
- There was a lack of consistency in the way the audit process was managed.

Leadership of this service

- Staff felt well supported by immediate managers throughout the service. Staff reported managers to be approachable and visible across the clinics.
- Staff told us there were opportunities for professional development and these were supported by managers. They told us they felt valued by the service.
- Staff were informed about changes to the service, through regular emails and had the opportunity to participate in the planning. It was reported there was good attendance at staff meetings.

Service vision and strategy

- Local values were 'be caring, be inspirational, be part of it'. Staff had knowledge of the values and we saw printed notices of values in prominent places for staff to see.
- Dental services were commissioned by NHS England. These services were due to be re-tendered and a business plan had been completed in preparation for the organisation to bid to continue providing community dental services.

- The service vision was to improve the oral health and reduce inequalities of people who have physical, sensory, intellectual, mental, medical, psychological and/or emotional or social impairment or disability. The strategy to meet this vision was through providing consultant-led care to people with more complex special care needs, and other vulnerable groups of people.

Governance, risk management and quality measurement

- There was a clinical director, who was supported by an operational lead. They were responsible for the day-to-day running of each clinic, the reporting of information to the Board and feeding back to the clinicians and dental nurses on the front line.
- Risk registers for the organisation were known locally as KORS – key opportunities, risks and success plan. The KORS for community dental services had four risks. The risks were evident from the inspection and senior staff were aware of them, however the KORS did not specify how the service was mitigating the risks. We did not see a link between the service level risk register and the organisational risks.
- Governance meetings minutes demonstrated standing agenda items of clinical issues, audit, safeguarding and incident reporting for discussion and actions were embedded in the minutes. However, the minutes did not provide timescales for actions or identify mitigating actions until completed.
- We saw evidenced in dental management meetings how issues from governance meetings were shared to the local teams and actioned.
- There was a lack of consistency in the management of audits within the service.

Culture within this service

- We observed staff to be passionate and proud about working within the service and providing good quality care for patients. The focus of staff was to provide a positive and caring environment, where patients were at the centre of all they do.

Are services well-led?

- Staff told us they worked as a team across the whole service. This was facilitated by staff working across the clinics and by engaging in whole service team meetings.

Public and staff engagement

- One senior dental nurse had responsibility for managing the services social media site. The site provided information about the service and also encouraged the public to contribute their views about the service.
- The service took part in the friends and family test, and also undertook their own patient experience surveys.

- Staff had been engaged in the planning and development of the bid process through staff meetings. There was some anxiety among staff around job security; however, staff felt they were adequately informed of the process and stages.
- Staff received regular updates and newsletters through email.

Innovation, improvement and sustainability

- The service had developed a central referral point and triage system to promote a clinically and cost effective service.
- The service was able to offer treatment and support to patients with phobias and high anxiety levels by having a staff member qualified in cognitive behaviour therapy.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>Regulation 18 (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part</p> <p>How the regulation was not being met</p> <ul style="list-style-type: none">Paediatric nurses were not available at Dewsbury District Hospital to provide recovery care for children receiving dental treatment under general anaesthetic. <p>Regulation 18 (2) Persons employed by the provider in the provision of a regulated activity must -</p> <p>Regulation 18 (2) (a) Receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform</p> <p>How the regulation was not being met</p> <ul style="list-style-type: none">Compliance rates for safeguarding children training were low in the community dental services.